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GYNECOLOGICAL SURGERY DURING THE CHILD BEARING AGE

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A discussion of gynecological surgery during the child bearing age is timely because inadequate knowledge of pelvic physiology, lack of understanding of the psychosomatic problems of young women, and the lack of conservatism on the part of some surgeons is causing expensive, unnecessary and often mutilating pelvic operations on young women. Hospital Tissue Committees should prevent this; they should strive to improve the surgical and medical practice within their hospitals, but all too often they employ the technique of "whitewash" rather than critical analysis.

The general practitioner is the medical foundation of a community; he is the family and the referring physician. It therefore becomes his duty and obligation to see that his patients receive the best medical, surgical and gynecological care.

In order that he may afford his patients this care, let us review some of the gynecological problems of young women and discuss the principles of their management and treatment.

The Ovarian Cyst

During the reproductive years, an ovarian cyst is more often a physiological than a pathological entity. Ovulatory and anovulatory cycles are capable of producing follicular and corpus luteum cysts. The discovery of an

ovarian mass in a young woman should prompt observation rather than surgery.

Surgery should not be considered unless the ovarian mass is greater than 5 centimeters in diameter, is opaque by x-ray examination, or shows progressive enlargement during 6 to 8 weeks of observation.¹ Moreover, most ovarian masses should be managed conservatively by observation unless they are firm rather than cystic or are twisted or associated with severe pain. The treatment of the benign ovarian cyst is cystectomy rather than oophorectomy or salpingo-oophorectomy. Radical adnexal surgery should be avoided in benign lesions of the ovary.

Pelvic Inflammatory Disease

The diagnosis of pelvic inflammatory disease is made too often, too loosely, and too quickly. Pelvic discomfort of almost any degree or type is diagnosed as "PID", and the patient is treated with hot douches and antibiotics. This is unfortunate since the disease occurs so infrequently among white private patients. What is presumed to be chronic salpingitis is more often psychosomatic pelvic pain.^{2,3} It is not surprising that a large percentage of psychosomatic discomforts in women is referred to the pelvis. Menstruation, coitus, and childbirth are fundamental functions in the lives of women. Therefore, when marital, sexual, family and personal difficulties arise psychosomatic pelvic pain may occur. The typical syndrome includes lower quadrant pain, which is usually deep without rebound, dyspareunia, vagin-

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ismus, adnexal discomfort, dysmenorrhea, premenstrual tension, and tension headaches. These women are afebrile, often relatively hypotensive and have normal leucocyte counts and sedimentation rates.

These patients need a physician who is an understanding friend, not an operation. The majority of these women will respond to superficial psychotherapy and be benefited by the occasional use of such drugs as Dexamyl, Daprisal (compounds of dextro-amphetamine sulfate and amobarbital) or small doses of testosterone.

When there is some real question of pelvic pathology, simple procedures such as posterior colpotomy, culdoscopy and utero-salpingraphy will establish the proper diagnosis. Exploratory laparotomy is seldom indicated.

When gonorrheal or tuberculosis salpingitis is present and associated with chronic pain, parametrial induration and tubovarian masses, there are 3 indications for surgery.

- 1) Patients who have large tubovarian abscesses which are likely to rupture and have failed to respond to bed rest and antibiotics.⁴

- 2) Patients who have such severe and chronic pelvic pain and debility, that they will consent to castration if it is necessary to eradicate their disease.

- 3) Patients with genital tuberculosis.⁵

When a laparotomy is done for extensive pelvic inflammatory disease, it should be a complete operation with extirpation of both tubes, uterus, cervix and irreparably damaged ovarian tissue. Surgery should be delayed until it is mandatory; it then should be complete. The piecemeal pelvic surgery that is so prevalent should be discontinued.

Myoma of the Uterus

The removal of the uterus during the child bearing age should receive the same consideration that one would give to the removal of a limb.

Myoma of the uterus should be considered as part of the normal process of aging. The mere presence of a myoma should not serve as an excuse or be considered an indication for hysterectomy or myomectomy.⁶ A patient should not be frightened into an operation by associating uterine fibroids with cancer. The operative mortality of hysterectomy is precise-

ly the same as the incidence of malignancy among myomas. Moreover, it should be remembered that myoma of the uterus will decrease in size after the cessation of menses.

There are however four indications for hysteromyomectomy.

- 1) Myomas whose responsibility for profuse and abnormal uterine bleeding has been established by eliminating malignant pelvic growths and endocrine imbalances.

- 2) Myomas which cause obstruction to the urinary and gastro-intestinal systems.

- 3) Myomas which cause pain because of size, location or loss of blood supply.

- 4) Myomas which cause uterine enlargement of at least 10 centimeters above the symphysis pubis.

The indications for myomectomy cannot be stated so categorically.⁷ The myoma should be of sufficient size to produce pain or alteration in normal uterine physiology, be located in such undesirable locations as the cervix or the endometrial cavity or be associated with torsion, necrosis or obstruction.

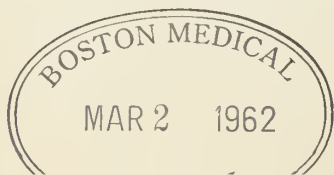
Myomas should be considered as deterrents to fertility only after all other causes of infertility have been eliminated. Myomectomy is not warranted purely because a patient is contemplating marriage or has failed to conceive.

Endometriosis

Hysterectomy is seldom indicated in the treatment of endometriosis during the reproductive years. These patients should be encouraged to become pregnant and should receive competent advice concerning infertility. If the disease process progresses, the conservative operation of TeLinde may be performed.⁸ This consists of resection of endometrial implants and endometriomas, presacral neurectomy and on occasion uterine suspension.

Menstrual Dysfunction

Abnormalities of menstruation are frequent during the early and late years of menstruation. There is no problem of cancer in the teenager and a curettage is generally not necessary. The abnormal uterine bleeding is secondary to an estrogen, progesterone and metabolic imbalance which can be treated satisfactorily with rest, nutrition and properly regulated cyclic therapy. If the bleeding be-



comes alarming, these young girls should be referred to a medical center for treatment rather than to surgery for hysterectomy.

During the third and fourth decades of life abnormal uterine bleeding may indicate carcinoma and require Papanicolaou smears, biopsies, and curettage. But hysterectomy for benign uterine bleeding should be delayed until the patient has finished her childbearing. These women may generally be managed satisfactorily with the occasional curettage, carefully regulated cyclic therapy and correction of their nutritional and emotional difficulties.⁹

Carcinoma of the Cervix

The treatment of invasive cancer in the child bearing age requires adequate and complete surgery or radiation, occasionally both. But an increasing number of uteri are being sacrificed because a few abnormal but nonmalignant cells are found on the Papanicolaou smear. The Papanicolaou smear does not make a definitive diagnosis of cancer. Suspicious cells do not indicate hysterectomy, but dictate that a proper gynecological diagnosis be made.

There are simple steps that may be taken to make a proper diagnosis when anaplastic cells are present on the Papanicolaou smear. If a cervical lesion is present, it should be examined by biopsy, as should the entire mucocutaneous junction. This simple procedure may be performed in any physician's office. If invasive cancer is not demonstrated, a cold knife conization and fractional curettage should be performed.¹⁰ When suspicious cells are found on a normal or completely epithelialized cervix, one should proceed immediately to a cold knife conization and curettage. Multiple sections of the conized tissue may reveal only cervicitis or squamous metaplasia which require no further treatment, carcinoma in-situ which occasionally may be followed conservatively, or invasive carcinoma of the cervix.

Invasive carcinoma of the cervix should be treated by adequate radium and x-ray. The use of radical hysterectomy in the treatment of

carcinoma of the cervix is still in the research phase of its development. It is an extensive operation that should be performed only in large medical centers. The employment of subtotal and total hysterectomy in invasive cancer of the cervix must be vigorously condemned. These procedures reduce the life expectancy of the patient and deny her proper radiological treatment. The uterus is a receptacle for radium; its absence materially reduces the amount of radiation that can be administered.

Carcinoma in situ is generally treated by total hysterectomy and removal of the upper third of the vagina; occasionally the lesion may be treated conservatively. The decision to treat carcinoma in situ conservatively depends upon the extent of the lesion and the degree of anaplasia of the cells. This decision is a serious one and should be made only by pathologists and surgeons who have considerable experience in the management of pelvic cancer.

Summary

There are five suggestions that may be made to improve the practice of gynecology and the performance of gynecological surgery during the child bearing age.

- 1) Take a careful gynecological history. Encourage patients to discuss their psychosexual problems.

- 2) Make the pelvic examination a part of each general physical examination. This will increase the proficiency of this examination.

- 3) Have a capable surgeon who practices outside the community discuss controversial gynecological cases and review tissue committee findings at staff, county medical society, and postgraduate meetings.

- 4) Become familiar with basic gynecological pathology, the treatment of malignant conditions in the pelvis, and the symptoms of pelvic psychosomatic disorders.

- 5) Refer your patients for consultation rather than definitive surgery to surgeons who are known for their conservative attitude toward pelvic surgery.

(For References See Page 17)

REFLECTIONS ON CANCER*

ROBERT LICH, JR., M. D.**

The opportunity to give the Rose E. Ramer Lecture is an honor which I am not quite sure should have fallen my way. After Dr. Clyde Bowie extended me this privilege I wondered what might be appropriate to justly honor your great benefactor, Mrs. Rose E. Ramer, and since this is an anniversary lecture it seemed fitting to attempt, in broad terms, an inventory of recent scientific and clinical considerations in cancer. This undertaking can not be spanned in a few minutes, but some concepts can be outlined with purposeful disregard for detail.

Let us review first what is meant by cancer. Cancer is a killer and still it is not some horrible monster. Specifically it is rampant embryonic cellular growth which robs the host of his nutrition and results in his destruction. For example, localized lining cells within the bladder suddenly grow rapidly forming a lump or mass which may project into the bladder and be readily visible to the urologist, or they may grow within the walls of the bladder and defy early detection. These cells demand increased nutrition and newly formed blood vessels grow into the tumor with great rapidity. These nutrient channels are youthfully delicate and the tumor cells in their hungry existence may penetrate the vessel and be carried to distant parts of the body where they initiate similar tumor masses which are known as metastases. Cancer then is a race for survival between these young edacious cells and their hapless host.

What is the cause of this cellular misbehavior? Are they entirely new cells that have been lying dormant, or normal cells that have gone metabolically astray, or is there some extrinsic cause, and why only a localized group of cells instead of all the cells in the body at once? The answers are yet to come, but we have accumulated some data of interest with

regard to some of these questions.

In urology we have at least one cancer that seems to be directly related to a chemical poisoning. Cancer of the bladder is extremely common among aniline dye workers, so common in fact that chemical companies demand that workers in these products have regular examinations for the early detection of bladder cancer. On the other hand, we have in urology a directly opposite situation wherein a chemical compound, stilbestrol, will hold prostatic carcinoma in abeyance for a variable period of time. Then in startling contrast some of the patients treated with stilbestrol for carcinoma of the prostate have developed a cancer of the breast during the time the drug was being used. Stilbestrol or female hormone seemingly has restrained one tumor and created another. It would seem here that chemical activity must be a prime factor since a chemical is the common denominator in both origin and control.

Duran-Reynals, at Yale University, has produced cancer in mice, using cortisone, vaccinia virus and methylcholanthrene in sub-carcinogenic doses. It was found however that if estrogen was added that embryonic connective tissue production was increased and cancer failed to develop. In other words, female hormone interrupted the cortisone depression of mesenchyme or embryonic connective tissue and prevented cancer.

Several authors have noted rejection, acceptance and the establishment of immunity in experimental cellular cancer transplants into humans and there is reason to believe that the serum properdin level of the cancer host is significant. Hence, we have here a possible clue as to why or how tumor cells find a fertile field in one and not in another individual.

Dr. Wendell M. Stanley at a recent meeting of the American Philosophical Society discussed the relationship of chemistry to cancer. He presented the findings that viruses, molecules and genes were closely related to the fundamental life substance, nucleic acid. He

*The annual Rose E. Ramer Lecture presented before the Piedmont Post-Graduate Clinical Assembly on September 19, 1957 at Clemson, South Carolina.

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pointed out that certain viruses have been broken down to protein and nucleic acid subunits and then reassembled to recreate the initial biologically active virus. Of course it has been long known that several animal cancers are caused by viruses. From the studies of nucleic acid the relationship of genes, viruses, cancer and life suggest the possibility that genes and viruses may produce causative effects interchangeably and the aftermath may be obvious to us as a cancer. Furthermore, we know that viruses may be ineffective in a host and later mutate with rapid host destruction. Also, viruses may be dormant over long periods, even generations, and suddenly erupt into killing activity. By the same token genes might well harbor a virus of cancerous effect which would not necessarily cause destruction in each host, but lie dormant and spring into activity under certain environmental circumstances and produce fatal cancer in a familial line with unpredictable distribution. Here again, it would appear that the chemical etiology of cancer is gaining confirmation though possibly from a different aspect.

Our greatest need today is a test for the early detection of malignant growth irrespective of its site. This need, in recent years, has become increasingly acute because as we are effecting total surgical extirpation we are finding an ever increasing number of multiple primary tumors in the same individual. For example, the patient cured of a bladder cancer is found ten years later to develop an unrelated malignant growth in another organ with no evidence of recurrence of the original cancer. Only a few years ago more than a single primary cancer was a curiosity while today it is commonplace with two or even three primary tumors occurring in variable succession over a period of years in the same individual. It now seems what we once considered a cure may still result in a failure.

In urology we have the advantage of being able to view the urinary tract either directly by cystoscopy, or indirectly, by urography. It is true that neither method is infallible, but actually the degree of accuracy outdistances the available diagnostic acumen in other systems of the body. Also, in urology we have one chemical test that determines the presence

of an increased amount of acid phosphatase in the blood. This substance may be increased in cancer of the prostate and though the test is not indicative of early cancer, and it is not totally specific, it does offer valuable assistance in diagnosis. It is, at least, a step in the direction toward which we must strive.

Lacking a laboratory test for cancer we must be alert to the earliest symptom or clinical finding no matter how trivial. In certain types of cancer symptoms generally appear early in the course of the disease, whereas, in other tumors the symptoms appear late, too late for curability. The reason for this difference is the character and location of the tumor. The delicately constructed bladder cancer that is constantly being massaged by the expanding and contracting bladder bleeds early because of the easily fractured fragile vascular spaces in the tumor. It must be emphasized and re-emphasized that this initial bleeding is usually slight, of short duration and seldom constant. A single episode of bloody urine may be the only indication of an early operably curable bladder tumor and a subsequent incident of bloody urine may not occur until the tumor is incurably extensive. A similar situation may occur in the kidney wherein the tumor demands profound vascularization and in the blood vessel's haste to accommodate the tumor's ravenous demands its walls are inadequate so that spontaneous rupture or vascular erosion permits blood to seep into the urine. Here again, as in the bladder, microscopic blood or a single minimal instance of visible bloody urine may be the only sign of early curable cancer of the kidney.

Now in the other extreme, we have such structures as the prostate and testis wherein the organ is enclosed in a firm dense tissue capsule. These tumors usually grow more slowly and are manifest only by early minimal changes in size, shape, consistency or configuration of the particular organ. In other words, genital cancer is not diagnosed by symptoms, since when symptoms are manifest it is far too late for a cure. Here it is the responsibility of the physician to make the diagnosis early and on every examination he must continually re-examine these organs irrespective of how many times they have been

found normal in the past. We as physicians must accept this responsibility and its diligent execution is our patient's only hope of early diagnosis and cure.

Speaking of treatment, it is apparent from what has been said that cancer is fundamentally a cellular disturbance and to effect a cure we must attack it at a cellular level. We wish not only to destroy the already altered cell, but also to prevent another cell in the same or other organs from undergoing malignant change. Present day curative treatment for cancer is limited to surgery or irradiation and both these methods are aimed toward the destruction or removal of the cancerous cells. Neither measure prevents the appearance of other tumors in the same or other organs and are no more logical therapeutically than the treatment of the fever in diphtheria or the muscle spasm of poliomyelitis. It may be said only, on the behalf of surgery and irradiation, that it is the best we have available today. Like the explanation of the inebriate stumbling around in the dark who threw a brick-bat through a plate glass window, it looked like the only thing to do at the time.

In the past few years radioactive substances have been combined with certain elements so that by metabolic activity of the disturbed cell the particular element with its radioactive attachment is engulfed with the resultant cell suicide. This is theoretically interesting, but its applications have not been dramatic.

Furthermore, infiltration of radioactive compounds into the tumor have been explored and again the result is more spectacular than real.

We in urology have seen evidence of the effectiveness of chemical therapy. Hormonal therapy in prostatic cancer and in some types of bladder cancer is purely palliative and not curative, but it gives us a glimpse of the potentiality of this type of treatment. Many of us have seen a patient take one or two pills a day and watch the tumor in the prostate change from a huge stony mass to a gland which felt normal and the metastatic malignant growth in the spine or pelvis producing invalidism and agonizing pain melt away and the patient be up and about with complete comfort within a few days. Needless to say this treatment is not always this spectacular, but it at least gives us hope for an eventual solution to our problem of cancer.

It goes without saying that we have discussed only a very small fragment of the cancer problem. We have during these minutes looked briefly at the overall picture and guessed, maybe badly, at the future. The actual amount of daily, weekly and monthly accumulation of experimental and clinical data is incomprehensible, but like the moving glacier our progress is slow. The solution to cancer is still in the future, but we are constantly closing this gap of separation.

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Auscultation of Faint Heart Murmurs. Dale Groom, M. D. (Charleston) Postgrad. Med. 22: 360, Oct. 1957.

Earlier diagnosis of valvular heart disease is facilitated by attention to the fainter, less obvious murmurs during an auscultatory examination.

The major factors determining one's ability to hear faint murmurs are discussed, notably the characteristics of human hearing and of stethoscopes, and technique of auscultation.

Background noise is likewise a determining factor,

as shown by a study of the thresholds of audibility of 40 physicians.

Measurements with a sound-level meter of the background noise levels on busy hospital wards and in clinic examining rooms indicate that these environments are not as quiet as is generally supposed and are not conducive to accurate cardiac auscultation.

Drastic reduction of such environmental noise will greatly enhance our ability to detect faint heart murmurs.

MASTOIDITIS IN CHILDREN

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Some may consider mastoiditis as a disease of the past. It is not uncommon to observe evidence of mastoid surgery on those who were in the younger age group before the advent of the many antibiotics. Such an observation is rare in the age group seen by the pediatrician currently.

A case of mastoiditis complicated by facial paralysis has been observed recently in Roper Hospital. This case has aroused the interest of several of the staff members in the problem of mastoiditis, and this endeavor to consider the subject is the direct product of interest in that particular case.

It is difficult to separate the suppurative processes of the middle ear from those of the mastoid cells. The communication between the two structures is quite frequent. In almost every instance, acute mastoiditis is secondary to a middle ear infection. Primary infection and inflammation of the mastoid process is very rare; however, there have been cases of mastoiditis reported in which the middle ear has not been involved. The blood stream is the usual route for the introduction of the infection in such cases. It is probable that in many cases of acute infection of the middle ear the mastoid cells are also involved. It is chiefly in those cases in which free drainage is diminished that the mastoid symptoms become manifest. Symptoms are produced chiefly by trapped secretions within the cells.

The case which we have recently observed is that of a four year old colored female apparently well until August 3, 1956 at which time she complained of discomfort involving her right ear. Examination revealed a bean lodged in the auditory canal. This was removed by the attending physician on the ear service with no immediate evidence of complication. The patient was discharged from the Emergency Room to have subsequent follow-up. Approximately four days after the extraction of the bean, right facial paralysis was

observed. The patient was admitted to Roper Hospital at that time. There was a right internal squint, a greatly distorted right ear drum, and a moderate amount of purulent material in the right auditory canal. Right facial paralysis was obvious, but the patient could open and close the right eyelids fairly well. The remainder of the physical examination was non-contributory. She had a mild leukocytosis. A culture of the material from the right auditory canal was reported as 90 per cent virulent *Staphylococcus aureus*. Roentgenograms of the mastoids demonstrated sclerosing and spotting in the right mastoid cells. The cell septa were indistinct. The left mastoid was clear.

The patient was given tetracycline at the time of admission, and remained on this for ten days. At the end of ten days tetracycline was discontinued. Penicillin G and streptomycin were begun. She was essentially afebrile during the entire hospital stay with the exception of one temperature spike on the 17th day of hospitalization. Examination at that time produced no apparent cause for the elevation, and the patient was again afebrile after 12 hours.

The patient was subjected to galvanic and faradic stimulation of the facial nerve in an effort to predict the response that might eventually be expected. With galvanic stimulation all facial muscles responded. With faradic stimulation there were no responses from the temporal, mandibular, buccal, or cervical branches of the right facial nerve. With these results, the attending physician elected to treat the patient with antibiotics rather than by a more radical approach.

Approximately eleven days after admission slight improvement in function of the right facial musculature was observed. The patient remained in the hospital for 10 days longer, and during this period increasing facial muscle function was noted. She was discharged, improved, after 21 days of conservative treat-

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ment.

Review of the charts in Roper Hospital showed that during the period from 1946-1956 there were only twelve cases of acute mastoiditis. Of these, eight were treated with antibiotics and four underwent mastoidectomy. Apparently, good results were obtained in each case. Unfortunately the follow-up on these cases was unusually poor. We would like to mention several of these cases briefly.

The first case is that of an 18 months old white female who had a bout of otitis media in September 1955. The patient was seen repeatedly following this in the pediatric clinic and ear clinic with evidence of recurring otitis media. She had been treated with penicillin and sulfonamides on several occasions. For three days prior to admission she was treated with oxytetracycline without evidence of improvement. The patient was admitted on January 15, 1956 with a diagnosis of otitis media, upper respiratory infection, and pharyngitis. Physical examination on admission revealed purulent drainage from the left ear, pharyngitis and slightly inflamed tonsils. Culture of the material from the ear was reported as *Pseudomonas* species 100 per cent, resistant to all antibiotics. Roentgenograms demonstrated left mastoiditis. The patient was treated with erythromycin on admission, and later penicillin and streptomycin were added. She also received neosynephrine nose drops.

It was elected to perform a tonsillectomy and adenoidectomy on this admission, after considering a long history of otitis media and the present complication of mastoiditis. The post operative course was uneventful, and the patient was discharged after ten days hospitalization. Follow-up on this case showed that the patient returned to the pediatric clinic three months after surgery with bilateral otitis media. She was given Gantrisin and penicillin on that visit. The patient returned one week later with much improvement of the otitis media. Since that time she has had no further difficulty with otitis or pharyngitis.

This case suggests that mastoiditis is a very likely complication of *recurring* otitis media, even though this complication is not suspected clinically.

The second case is that of a 12 year old

colored female who gave the history of a chronic draining ear since three years of age. At age 3 the patient was reported to have stuck a match in her right ear. She had had one previous admission for otitis media. For 3 days prior to the admission with which we are concerned, the patient complained of pain in the right ear. Just prior to admission a generalized convulsion and temperature 105° were recorded. Roentgenograms revealed acute right mastoiditis. Result of a culture of the exudate from the right auditory canal was reported as *Pseudomonas*, slightly susceptible to chloramphenicol. On physical examination a swollen, tender area over the right mastoid was evident. The day following admission the patient underwent right radical mastoidectomy. The procedure was well tolerated and there was no evidence of complication. Following the surgical procedure she received penicillin 300,000 units b. i. d., chlortetracycline 250 mg. every 4 hours and nitrofurantoin ear drops. After approximately 2 weeks of antibiotic therapy these medications were replaced with sulfadiazine. The patient was discharged to clinic apparently completely recovered after 36 days hospitalization. There is no clinic record of follow-up available.

This case points out that 9 years of conservative therapy had been to no avail, and that a complete cure was apparently accomplished after radical mastoidectomy.

The next case is that of a 12 year old colored male admitted with history of headache of only three days duration. Physical examination demonstrated marked tenderness over the left mastoid area. Roentgenograms showed acute exudative mastoiditis on the left. Treatment consisted of penicillin for nine days, then sulfadiazine for five days. Following this, penicillin treatment was resumed for the next five days. The patient demonstrated marked improvement on this regime, and was discharged after 14 days of treatment. There is no indication of recurrence or complications.

This case points out that even though the ear infection was of very short duration, the mastoid complication was observed to be severe.

The next case is that of a five year old colored male with a history of frequent upper

respiratory infections. One month prior to admission the patient had measles and chicken pox. As these two processes were subsiding the child developed otitis media with intermittent purulent drainage. Treatment in the pediatric clinic consisted of hydrogen peroxide irrigation and an oral sulfa preparation. Three days prior to admission the patient had a sulfa preparation forced into the left ear with a bulb syringe. Shortly afterwards he developed post auricular swelling and high fever, with erythema and tenderness over the mastoid process. Roentgenograms revealed acute left mastoiditis with some destruction. The surgical consultant elected conservative treatment with surgery if indicated only after the acute infection subsided. The patient received penicillin 300,000 units b. i. d. and neosynephrine nose drops. After 13 days of treatment, he was discharged much improved.

This case is a good illustration of the efficiency of antibiotics in a case in which surgical intervention seemed indicated in the earlier course of the illness.

Reviewing the literature on acute mastoiditis was somewhat disappointing; however, the approach to the management in most cases of acute mastoiditis was an attempt to effect a cure with intensive antibiotic therapy, and if this method failed, the surgical approach was employed.

Discussion

It would appear from various studies in recent years, especially since the advent of the antibiotics that mastoiditis is becoming a rare disease. However, the occasional sprinkling of cases is indicative of several points: one is that

otitis media remains a condition that demands proper and adequate therapy to prevent complications; and another is, as pointed out by the case that we have recently observed, that we must be aware of mastoiditis as a complication in cases that do not arise originally as otitis media.

From the review of hospital records and of the literature, it appears that the greater number of cases of mastoiditis can be adequately controlled with the antibiotics which are available today. There are those cases, however, which we occasionally see that are quite resistant to conservative treatment, and must be handled surgically in the manner that was practically the routine before the availability of antibiotics.

Conclusions

- 1) Mastoiditis is a frequent, although not always recognized, complication of otitis media.
- 2) Most cases of mastoiditis can be adequately managed with antibiotics.
- 3) There are occasional cases of mastoiditis which require surgical incision and drainage for adequate control.
- 4) Mastoiditis should be suspected and the possibility eliminated in all cases of otitis media and trauma to the auditory canal and middle ear.

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Experiences in the Treatment of Human Beings with Antirabic Vaccine in South Carolina. G. E. McDaniel, M. D. South. M. J. 50:1369, (Nov. 1957)

Antirabies vaccine, whose use is not without danger, is used all too frequently in the absence of definite indications. Antirabies vaccine was not indicated in 35-40% of individuals given the vaccine in South Carolina between 1953 and 1955. The vaccine should not be given without careful evaluation of each patient and his specific need for the vaccine. During the per-

iod 1950-1951, there were six deaths from rabies and three deaths from post-rabies vaccine encephalomyelitis. The use of hyperimmune serum in cases with severe bites about the face and neck by rabid animals greatly reduces the probability of the development of rabies. Serum must be given early and must be followed by the usual course of vaccine. The rabies control program in South Carolina is accomplishing good results in reducing animal rabies and human treatments.

NEWER CONCEPTS IN DERMATOLOGY

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The title "Newer Concepts in Dermatology" might lead the speaker into a treatise which would last for several hours. In the time allotted only the high spots of some of the newer concepts can be treated and then only briefly.

I have just returned from the meeting of the Eleventh International Congress of Dermatology which took place in Stockholm. There were no startling new developments, however attempts were made to clarify many situations which have complex issues. Great stress was laid on the relationship of cutaneous lesions to systemic disease. The term "Cutaneous Medicine" is becoming a reality. The picture of dermatology is rapidly changing and the dermatologist must have a knowledge of internal medicine in order to adequately practice his speciality and to intelligently respond to the questions asked by his confreres in other fields of medicine. Those of us who are engaged in teaching graduate and undergraduate students constantly stress the relationship of skin eruptions to systemic disease.

One recent development which should gladden the hearts of all practitioners is the development of a council on nomenclature which has the difficult task of trying to simplify the complex terminology which we inherited from our forbears. Those of us on this committee have embarked on a long tedious journey into a mysterious set of weird terms and we hope to be able to bring order out of chaos. Such fantastic terms as ectodermosis erosiva pluriorificialis, and erosio interdigitale blastomycetica have been obviated by the passage of time and will slowly drift into oblivion in the next few years.

In recent years I have been studying a group of conditions which I have referred to as reaction patterns. To simplify this we might state that a given stimulus is productive of a

different type of reaction in different individuals. It is quite obvious that a condition such as seborrheic dermatitis may be produced by emotional stimuli and also possibly by food sensitization. The clinical picture referred to as atopic dermatitis may be due to food or drug sensitivity, inhalation sensitivity, or emotional tension. At times the lichenoid dermatitis associated with atopic dermatitis may actually be the indication of an underlying lymphoma such as Hodgkins' disease or other lymphoblastoma. Urticaria may indicate emotional tension, a sensitivity reaction or some underlying malignant growth. This study of reaction patterns emphasizes the fact that the patient must not be treated from the standpoint of topical therapy alone but must be regarded as an individual who has some disease and must be thoroughly studied from the standpoint of physical examination and laboratory studies in order to arrive at a proper diagnosis. Relatively few conditions can be cured by the application of an ointment or lotion alone.

Since the development of steroid therapy much attention has been devoted to that group of conditions which have been classified as the collagen vascular diseases. Lupus erythematosus has received the greatest attention, and many hours might be devoted to a discussion of this entity alone. Fifteen to twenty years ago chronic discoid lupus erythematosus was considered to be a condition which was separate and distinct from disseminated lupus erythematosus. At that time it received the name lupus erythematosus because of certain similarities in the pathologic picture. Now we are aware of the fact that chronic discoid lupus erythematosus is just another phase of the entire disease picture. We have been able to document the fact that approximately five per cent of all patients who have the condition known as discoid lupus erythematosus eventually develop the disseminated picture. Under the old system of therapy it was considered

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proper treatment to apply carbon dioxide snow to the discoid lesions or to paint them with phenol. Such drugs as bismuth subsalicylate by intramuscular injections and gold sodium thiosulfate by intravenous injection were considered the most desirable forms of therapy. In the light of our more recent knowledge it is quite possible that these two methods of treatment were of no practical value. Each patient on whom the diagnosis of lupus erythematosus was made should have a thorough physical examination, complete blood picture, lupus erythematosus cell study, albumin-globulin ratio, and roentgen examinations of the chest. If these studies are negative, treatment may be instituted with one of the anti-malarial drugs. A few years ago, one of our British colleagues determined the fact that atabrine was a very valuable drug in the treatment of chronic discoid lupus erythematosus. Its major drawback was the production of yellowish pigmentation in the skin. Since the time of this report we have used other anti-malarial drugs such as camoquin and aralen with equal degrees of success. These drugs are of no value in the treatment of the disseminated variety of the disease but produce partial remission of lesions in the discoid variety. A patient with discoid lupus erythematosus should never be completely discharged but should return for periodic observation even after all of the erythema has disappeared from the lesions. These patients should have a complete physical examination and blood picture and lupus erythematosus cell studies done once each year.

The development of steroid therapy opened a new vista in the treatment of disseminated lupus erythematosus. If therapy is initiated with cortisone, hydrocortisone, ACTH, prednisone, or prednisolone in adequate dosage and is carefully controlled it is quite possible that patients may be kept alive for an indefinite period of time on a maintenance dose of the drug. It must be emphasized that these drugs do not cure lupus erythematosus but they do produce a remission of symptoms. Prednisone and prednisolone are not without adverse effects but it is far better to have a live patient who has gained some weight or has a follicular eruption than to have no pa-

tient at all. At present I have 6 patients under observation who have disseminated lupus erythematosus and who have been on continuous steroid therapy for the past 6 years.

We have become increasingly more aware of the fact that emotional stimuli may be productive of cutaneous lesions. The tranquilizers have been of a great value in producing relief from emotional tension. When the emotional tension has been relieved, in many instances the subjective symptoms of itching have subsided. Occasionally the services of a trained psychiatrist is required, however in most instances the family physician is able to help the patient. Emotional stimuli may be productive of various types of cutaneous lesions which vary from single chronic lichenified lesions behind one ear or on the back of the head to a generalized exfoliative dermatitis, or urticaria. These patients are seldom benefitted by the simple prescription of an ointment or lotion. They need intelligent care and a willing ear. Such drugs as Atarax, Miltown, and the barbiturates are of benefit in many instances but they are merely adjunctive measures in the treatment of disease. The physician who believes that he is obtaining an excellent result in the treatment of his patient with one of the tranquilizing drugs must not overlook the possibility that he is dealing with a placebo reactor. During a recent study we have encountered quite a few of these and find that it is quite difficult to evaluate any drug purely on the basis of subjective symptoms alone. These drugs should be used intelligently.

The application of steroids in lotion or ointment base has been of great value in relieving subjective and objective symptoms in such conditions as pruritus ani, pruritus vulvae, neurodermatitis, scborrheic dermatitis and atopic dermatitis, however these drugs do not cure but merely relieve the symptoms temporarily. In the vast majority of instances the symptoms recur when treatment is discontinued. Such therapy accomplishes a major purpose in that it allows the physician time to thoroughly study his patient. If he can remove the precipitating factor he may cure the patient. Before using the steroid preparations topically, I suggest that you carefully evaluate the case and determine the diagnosis.

These drugs are expensive and should not be wasted. When used where indicated they are very effective.

Systemic steroid therapy using ACTH, cortisone, hydrocortisone, prednisone, and prednisolone is of great value in the treatment of pemphigus vulgaris, lupus erythematosus, exfoliative dermatitis, severe eczema, dermatitis venenata, erythema multiforme, but relatively few other conditions. You must bear in mind the fact that these drugs do not produce cures but do produce relief from symptoms. It must also be understood that prolonged therapy with steroids may be dangerous in that adverse reactions may develop which may endanger the life of the patient. It is well to bear in mind also that the physician has three duties, first to cure the patient of the condition he had, second to get a live patient and third not to produce some symptom which he did not have when he originally appeared.

In instances where prolonged steroid therapy is necessary it may be wise to cover this with an antibiotic. This is sometimes necessary when such conditions as furunculosis or carbunculosis develop. It is quite apparent that prolonged steroid therapy does alter the patient's immune status.

Topical antibiotic therapy is of value only in the treatment of the pyodermas and in other dermatoses complicated by secondary pyogenic infection. It is wise to select an antibiotic for topical use which will not be used systemically.

Systemic antibiotic therapy in dermatology

is of value in very few conditions. It should be reserved for the use of the deep seated pyodermas such as furunculosis, carbunculosis, cellulitis, lymphangitis, and granuloma inguinale. In some cases of erythema multiforme bullosum it is of value either alone or in combination with one of the steroids. Where there is necessity for prolonged steroid therapy such as in pemphigus vulgaris or lupus erythematosus one of the broad spectrum antibiotics should be combined with the steroid.

Antibiotic therapy in dermatology and in other fields of medicine has recently been complicated by the development of prefabricated combinations of antibiotics which have been directed at the treatment of resistant strains of bacteria which are constantly encountered. The changing nature of our bacterial population which has been brought about in a large part by the indiscriminate use of antibiotics has necessitated further study and constant development of new drugs. There is little evidence that any prefabricated combination will ever meet the physicians' needs in the treatment of bacterial disease. Those of us who have been in the field of clinical investigation have urgently requested the various manufacturing companies to produce the antibiotic and to allow us to make our own combinations as the need arises. We can only determine what drugs we need by the proper use of the tube dilution sensitivity tests. It is quite possible that in the next few years the antibiotics that we have been using with great success will have become obviated.

"As a reluctant witness of the present deterioration in American medical education and of the threat of the still worse deterioration in store, I warn you in tones that are neither shrill nor strident that the members of the medical profession should begin to pay back what they received from endowments, gifts, and public taxation and that laymen should be made

aware, too, of the price they will pay if medical schools cannot train doctors as they know how to train them. As an old Frenchman said to a friend of mine, 'Remember, my boy, you can have anything you want in this world, but don't forget to pay for it'."

Challenges to Contemporary Medicine. Alan Gregg.

HYPERTENSION DUE TO THROMBOSIS OF THE RENAL ARTERY

A CASE REPORT

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Seneca, South Carolina

On December 7, 1955, I was called to see the patient for a chief complaint of severe pain in the right flank, radiating downwards and medially toward the bladder. The history and physical findings were typical of right renal colic and he was placed in the hospital for further investigation. Pus cells and red blood cells were found in his urine and although a flat roentgenogram of his abdomen was normal at this time it was felt that he had had a renal calculus as a cause of these symptoms. After five days he was discharged but two days later had a recurrence of the pain, this time located in the left flank; the pain was severe and colicky in nature and had the feeling, "as if something had slipped from my left kidney." Pus and red blood cells and one plus albumin were noted in the urine on this admission. Blood pressure ranged from 180 to 200 millimeters of mercury systolic.

I had seen this patient for several years and his blood pressure had never been over 160 to 170 millimeters of mercury systolic before. He had been known to be a mild hypertensive but had no symptomatology.

On November 18th, eleven days from the initial episode, he was referred to a urologist for consultation. Roentgenograms of the chest, intravenous pyelograms, as well as the retrograde pyelograms, gallbladder and upper gastro intestinal tract films were reported as essentially normal aside from some ileus of the colon. During this hospital admission he was seen in consultation by a general surgeon because of the possibility of some intra-abdominal surgical lesion. Due to the absence of physical findings and the rather serious subjective complaint, the surgeon felt this was a matter of tension or anxiety and this possibility was discussed with the patient at some length. He was put on chlorpromazine 25 mg. every six hours and meprobamate 400 mg. four times a day and discharged. Following discharge the patient was seen in my office and at his home rather frequently but he continued to complain of headaches and weakness. I attempted to reassure him as much as possible and gave him a variety of symptomatic medications, among them reserpine, hydralazine, ercafital, meprobamate and chlorpromazine.

On December 13, 1955, he was referred to an internist for diagnosis. The following diagnoses were made: hypertension, essential, moderately severe, with anxiety superimposed, including cephalalgia. During this hospital stay the patient recalled having received a very mild glancing blow across the middle of the

back some three months previously while unloading telephone poles. The blow was not serious, he was not seen by a physician and he continued his work. To the patient this was a very mild accident and he saw no connection between this and his present illness.

A regitine test (5 mg. intravenously) was performed on December 19th and showed a 25 mm. mercury diastolic drop. Although pheochromocytoma was not excluded it was felt unlikely that this was of any real significance. On December 27th the patient was again seen by the internist who made a diagnosis of hypertension, essential, in an emotionally unstable individual, migranoid headaches and vasomotor rhinitis. During this period he was seen by a neurosurgeon who felt that there was an irritation of the upper cervical roots and a functional headache. The neurosurgeon stated that on fundoscopic examination there was very little in the way of vascular changes. Following this examination the following blood pressures were recorded in my office:

December 17th	200/115
December 21st	180/105
December 23rd	195/110
December 27th	175/110
January 4th	180/105
January 7th	190/115
January 11th	190/115

The patient was taking pentolinium tartrate, reserpine, and hydralazine at this time.

January 18th	205/115
January 21st	185/110
February 6th	220/120

I consulted with Dr. Edgar Hines of The Mayo Clinic who felt that in spite of the examinations to this date a positive diagnosis had not been accomplished. It was his suggestion that we refer him to a medical center for complete diagnostic workup. Because of the accessibility of Emory University the patient was referred to the diagnostic clinic at that institution, and he was admitted on February 27, 1956. Following initial examinations and early laboratory findings, a diagnosis of accelerated or malignant hypertension with hypertensive encephalopathy was made. The latter opinion was based on the nervous and emotional irritability of the patient, the blood pressure level of 240/140 and the findings of bilateral papilledema of the ocular fundi. A renal basis for the hypertension was suspected because of the presence of four plus albumin and red and white blood cells in two urine specimens. On February 29,

1956 another film of the abdomen was taken as a follow up of intravenous pyelograms made the day before and revealed a small fleck of retained dye in the left renal parenchyma. This finding cast further suspicion on the possibility of pathologic change in the left kidney. Accordingly the patient was scheduled for retrograde pyelography by Dr. Chandler Guy, since further study and comparison of the new intravenous urograms with those made in November 1955 suggested that the left kidney had undergone considerable atrophy. Dr. Guy's report demonstrated conclusively that the left kidney had shrunk by approximately one third to one half since November 1955.

At 3 P. M. on March 1st the patient was noted by the nurse to be unable to hold a thermometer in his mouth and he appeared to have weakness of the right arm and leg, right eyelid and the right side of his mouth. His blood pressure was recorded at 240/138. A house officer was called and a diagnosis of cerebral vascular accident was made. Lumbar puncture showed an opening pressure of 205 mm, a closing pressure of 95 mm, with faintly pink spinal fluid. The patient had a generalized convulsion at 6:45 P. M. Immediately following, his blood pressure rose to 280/140. His stupor deepened into coma and he became totally unresponsive. At 2 A. M. he became markedly restless, cyanotic and apneic. He was pronounced dead at 2 A. M. March 2, 1956.

On autopsy, Dr. Hubbar of the Emory Hospital pathology staff found there were changes in the brain and kidney. The brain showed intracerebral hemorrhage of the left hemisphere which had dissected into the left ventricle and downward into the left cerebral peduncle. The left kidney weighed 90.5 grams and the right 192.5 grams. The surface of the left kidney was irregular and a small amount of fat and fibrous tissue was markedly adherent to the mid-portion, particularly in the lateral and posterior areas. The capsule stripped with ease at the poles but not in the mid-portion. There was evidence of deep indentation of the mid-portion of the kidney with two lobulated structures at the poles where normal kidney parenchyma was evident. On section, irregular, yellowish pink, firm scar tissue permeated the kidney ex-

tensively, starting from the mid-portion near the upper pole and ending near the lower pole. At the mid-portion it appeared to involve the entire parenchyma of the kidney. The basic architecture of the kidney was preserved; however, there was no distinction between the cortex and medulla in the area of fibrosis. On microscopic examination there was evidence of an area of old infarction in the right kidney. Sections of the mid-portion of the left kidney showed infarction with extensive ischemic necrosis and replacement by hyalinized fibrous tissue. The remaining ghost outline of the structure could still be demonstrated. There was some calcification of the medulla with extensive fibrosis and several necrotic areas containing chronic inflammatory cells were present.

It was the opinion of all in attendance that the blow to the back, though deemed insignificant at the time when received in late October or early November 1955, set up a chain of events which resulted in the death of this patient. The thrombosis of the renal artery followed by massive ischemic changes in the left kidney resulting in its shrinkage and atrophy most likely occurred as a result of the trauma. The renal atrophy representing true unilateral renal disease led to the rapid progression of the hypertension into a malignant phase with hypertensive encephalopathy.

A positive diagnosis of unilateral renal disease producing hypertension had been made and immediate plans for removal of the kidney were made. Unfortunately six hours later the patient suffered a massive cerebral vascular accident and died before surgery could be instituted.

Summary

A case of unilateral kidney disease following trauma and causing malignant hypertension, cerebral hemorrhage and death is reported. A chronological account of events from first visit to death of the patient has been attempted in order to give a clear understanding of the problems involved in diagnosis and treatment.

"Death is absolute, unique, and certain; illness is relative, multiform, and seems fortuitous. Except in murder, war, capital punishment, and suicide, death requires no collaborators; sickness calls for, and from time immemorial has received, help from others, whether they be guided by superstitious terror, compassionate charity, or medical science. From such contrasts it is easy to see that disease presents to the human mind a far more complicated concept with which to reckon than does death. This, I suppose, is the reason why insurance against death has easily become a vast and exact business, while insurance against illness, like a creature struggling to emerge from its chrysalis, is caught in a strait jacket of

tradition, ignorance, inadaptability, and fatalism. I am tormented to watch so slow an emergence, knowing what Great Medicine could do if it were only freed to move and grow. That is the purpose of this book: to help to free Great Medicine, if only in the minds of a small number of readers, to emerge from its chrysalis. No well-trained physician can contemplate the cribbed, cabined, and confined potentialities of medical science without making the choice between protest and cynicism, between action and apathy, as a way to adjust that vision to the wretched realities of today."

Challenges to Contemporary Medicine. Alan Gregg.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

ACUTE POSTERIOR MYOCARDIAL INFARCTION

DALE GROOM, M. D.
Department of Medicine

Case Record—The two tracings illustrated below were taken three days apart on a 45 year old business man. He had been under unusual stress in his work for about three months, had complained of indigestion, and had lost weight. On two occasions during this period he had experienced pain in the chest with an associated paresthesia extending down the right arm. Both attacks had come on at rest, were of brief duration, but were of sufficient severity to cause him to consult his physician.

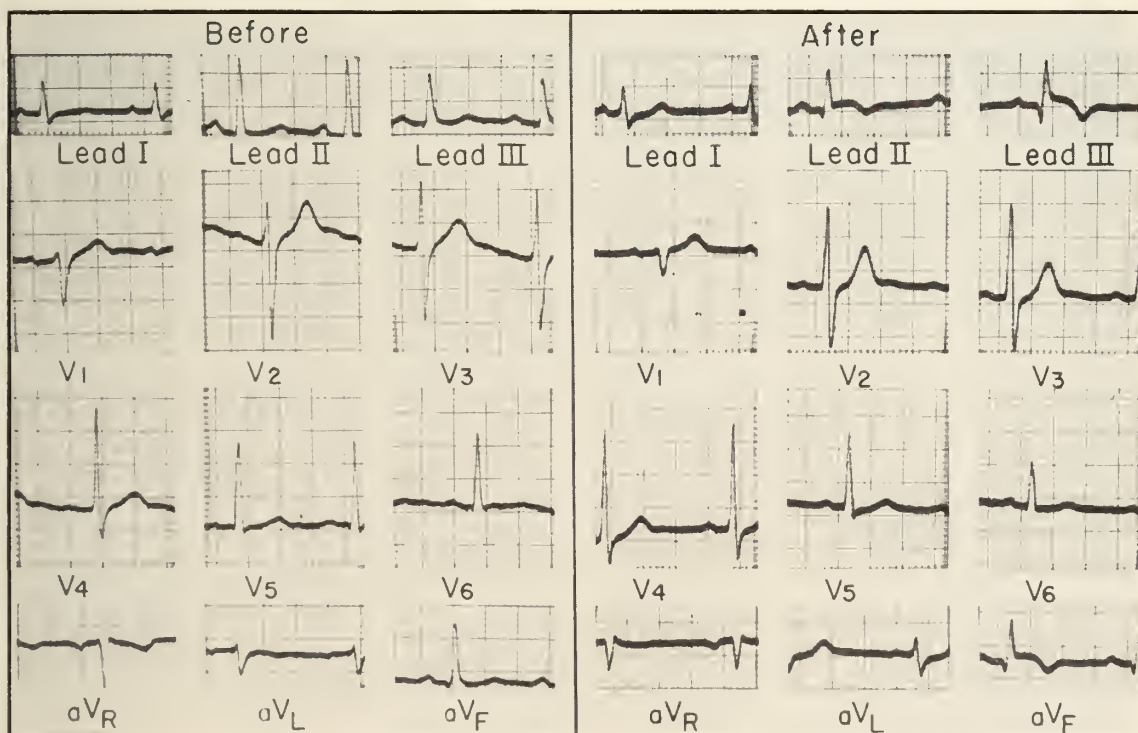
Physical examination at that time, when the electrocardiogram on the left was taken, was not remarkable except for occasional extrasystoles. The patient was subjected to a Master 2-step test which produced neither angina nor significant electrocardiographic changes.

A third attack occurred three days later, similar to

the others but with more severe pain which was unremitting. The patient was immediately placed in the hospital for treatment of acute myocardial infarction and the ECG on the right was recorded. After several days his pain abated and did not recur. His recovery was uneventful, although evolutionary T wave changes were observed in subsequent electrocardiograms for more than a year.

Electrocardiogram—The tracing before infarction is within normal limits. Its P - R interval measures 0.20 sec., and there is some "flattening" of T waves in leads I and V-6 but these can hardly be considered of diagnostic value even in retrospect. The fact that the QRS is an upward deflection in aVf and a downward one in the unipolar leads from both right and left arms indicates that depolarization is directed toward the left leg—a vertical electrical axis.

After infarction fairly prominent Q waves have appeared in leads II, III and aVf. In the latter two they are about 0.04 sec. in width. Accompanying the Q waves is elevation of the S-T segments one millimeter or more followed by rather sharply and symmetrically inverted T waves. No real abnormality has appeared in the precordial leads. However, comparison of the before and after electrocardiograms, taken with the same normal standardization, reveals that the R waves



in V-2, 3, and 4 have become higher following infarction, the T waves taller and more discreet, and perhaps minimal depression of some S-T segments has developed though this amount is seldom noted. Not all these alterations are attributable to variations in placement of the precordial electrode.

Discussion—The changes following infarction in this case are only moderate in degree but illustrate most of the classical electrocardiographic abnormalities, particularly in contrast to the previous normal tracing. The infarcted area is situated mainly on the inferior aspect of the posterior wall—that is, the area of the heart facing the diaphragm and hence the left leg electrode, aVf. Therefore that lead, and also standard leads II and III which are “bipolar” leads taken between the left leg and the upper extremities, can be expected to best portray the electrical abnormalities arising in that area of the heart. In infarction these are: elevation of the S-T segment early, usually with the development of abnormal Q waves and often a decrease in amplitude of the R waves early in the acute stage, followed later by sharply and symmetrically inverted T waves which may gradually return to normal over a period of months. The fact that the S-T segment is displaced upward in leads from the left leg indicates that that electrode is effectively facing the injured area of muscle. On the opposite side of the heart, where normal muscle tissue intervenes between the site of origin of the current of injury and the electrode, the displacement is downward. Thus the *reciprocal* S-T shifts so characteristic of acute myocardial infarction. Only suggestions of downward displacement are apparent in this case, in leads I, aVI, and perhaps V-5.

Localization of infarcts on the posterior wall is less precise than in the case of the anterior wall which is accessible to the multiple precordial leads. However it is often possible to discriminate electrocardiographically between an infarct which is situated mainly in the inferior or diaphragmatic area of the heart, and one which is confined to the so-called “true posterior wall” facing the back. The basis for such distinctions is more clearly understood if one visualizes the different leads as different electrical “views” of the heart from the positions of their electrodes. In the case of an infarct which faces the back of the chest, over which no routine lead is ordinarily recorded, the typical electrocardiographic changes described above for the more common diaphragmatic localizations may be minimal or absent. A clue of its presence in the acute stage is often provided by reciprocal S-T depressions elsewhere, usually in the right precordial leads, and resort to an exploring electrode over the posterior chest wall may reveal the characteristic pattern of infarction. Excellent demonstrations of old infarcts in this area can be achieved in esophageal leads by having the patient swallow a small electrode and recording the potentials from the posterior aspect of the left ventricle at levels below the A-V groove (which is conveniently identified by

contour of the P waves).

Extension of an infarct posterolaterally is suggested by the appearance of significant Q waves in the left precordial leads, including V-7 and V-8, and occasionally in leads taken from high in the left axilla. It should be pointed out that small Q waves are present normally in some leads from the left side of the heart, depending largely upon individual differences in its anatomical position. These normal Q waves are generally ascribed to initial activation of the interventricular septum occurring from left to right prior to spread of the excitation wave through the main mass of ventricular muscle. Of the significance of Q waves it can be said that the wider and deeper they are, in other words the greater their area, the more likely they are to be significant of infarction. A Q wave of 0.04 sec. or more duration in these leads is almost certainly a pathological Q wave. This is especially true in the *absence of a prominent S wave in lead I*.

The precordial leads, as a rule, contribute little or nothing to the diagnosis of posterior myocardial infarction. Because they confront a different area of the heart they may remain quite normal as this case illustrates. Nevertheless some interesting manifestations are often observed in these leads, especially on sequential tracings. In addition to the reciprocal S-T depressions already cited there are two other secondary changes which occur with sufficient frequency to merit attention. Damage to the posterior ventricular wall may cause the T waves over the anterior chest to become unusually high and peaked. And occasionally the R waves themselves increase considerably in height, even to the point of simulating in V-1 and V-2 the pattern of right ventricular hypertrophy. Minor indications of these are evident on comparison of this patient's tracings before and after his infarction. A plausible explanation lies in the consequent obliteration of electrical potentials of opposite direction which are normally produced by the posterior wall of the left ventricle, leaving those of the anterior and right ventricular wall relatively unopposed. Conceivably a large enough infarction of the left ventricle might result in a preponderantly right ventricular electrocardiogram.

It is of interest that this patient's attacks of chest pain—and his ultimate coronary occlusion—came on at rest. Angina was not present on exertion nor was it precipitated by the Master exercise test. This points up the fundamental independence of angina and coronary thrombosis which is understandable in view of the known facts that thrombosis can occur in a normal blood vessel and that factors other than size of the lumen of the vessel are involved in clot formation. Careful questioning of these patients will usually reveal that their symptoms of acute infarction came on after rather than during exertion, characteristically during a lull in activity or at a time when blood pressure might be expected to be declining following stress, with a resultant slowing in the rate of blood flow.

TUBERCULOSIS—A SHORT PROGRESS REPORT

FRANK L. GEIGER, M. D.

New estimates of the prevalence of tuberculosis in the continental United States were formulated in the fiscal year 1957.

At the beginning of 1956 there were 800,000 tuberculosis cases in the United States and 6065 cases in South Carolina significant for public health supervision. Of these numbers, 250,000 in the United States and 2346 in South Carolina were active cases. These data represent a decline from the last estimate in the United States in 1952 of about 15 percent in the total number of significant cases—about 30 percent in the active and 10 percent in the inactive groups. In South Carolina the decline has been 6 percent—5 percent and 18 percent respectively.

These latter figures point out that in this State there has been a less dramatic decline in significant tuberculosis cases and in active cases during the past five years as compared to the United States as a whole.

In the evaluation of antimicrobial treatment of tuberculosis, a number of notable contributions were made during the past five years that materially affected patient treatment. The over-all superiority of

isoniazid plus para-amino salicylic acid was confirmed, but preliminary results of a study not yet completed indicate that daily streptomycin plus pyrazinamide may be as effective therapeutically, although more toxic.

In the tuberculosis prophylaxis trials of the United States Public Health Service among human beings, about 2600 children are under observation to determine the effectiveness of isoniazid in preventing tuberculous meningitis and other complications of primary tuberculosis in children. The initial report on results were to be available in October, 1957.

Studies to test the effectiveness of isoniazid in preventing infection among the uninfected and the development of tuberculous disease among those already infected began in October, 1956. (Aiken and Charleston Counties are participants in this study).

This study which is focused on families of newly diagnosed tuberculosis patients covers fourteen communities in the United States. Each locality places under study the household contacts of each new active case of tuberculosis at the time the case is discovered.

Respiratory Arrest Following Administration of Intraperitoneal Neomycin. B. E. Ferrara, M. D. and R. D. Phillips, M. D. (Charleston) Am. Surgeon 23: 710-712, Aug. 1957.

The authors report two cases in their clinical experience in which respiratory arrest occurred following the intraperitoneal administration of neomycin. In each case recovery was complete. In one case the respiratory arrest lasted for fifteen minutes, in the other for five hours. It is stated that previous oral administration of neomycin enhances the toxicity of the drug when it is administered into the peritoneal

cavity. The production of respiratory arrest by the intraperitoneal administration of this drug had been produced in laboratory animals by other authors. The authors are convinced of the effectiveness of neomycin as the antibiotic of choice for preoperative bowel preparation. Due to the complication reported they urge caution when using the drug intraperitoneally. The total dose so given should not exceed three grams of neomycin in a one per cent solution. If used in quantities not in excess of this dosage no complications should occur.

GYNECOLOGICAL SURGERY DURING THE CHILD BEARING AGE: FLOWERS

(Continued From Page 3)

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PRESIDENT'S PAGE

The affairs of the state Medical Association are operated by the House of Delegates through the official representation of each county. This system brings together many of the interested and representative members of our Association.

Our present system does not, however, lead to the best functioning of our County Medical Societies. The presidents of the local societies are generally senior members who may or may not have had experience in the State Association. The secretaries and treasurers are usually younger members who have had little or no experience in organized medicine.

In order to aid the newly-elected officers of each county Society, a meeting was set up last January to furnish them with helpful information. On January 26, 1958, a similar session will be held in Columbia. On the program we will have an experienced speaker from the A. M. A. Staff. The state Association treasurer will explain the dues required from various type members. The president of the Blue Shield will tell what is going on in that field. A representative of the Medical College faculty will outline the work being done there with a view of letting the officers know what men will be desirable speakers for local society programs. There will also be chairmen of the Committee on Allied Professions and other committees who will lend information to the county society officers.

It is the sincere hope of the Association that this meeting will strengthen our County Societies.

Editorials

HYPERTENSION

Although isolated comments on the significance of elevated arterial pressure have appeared in medical writings for over 100 years, hypertension and hypertensive disease have emerged as clinical concepts only in the past 40 to 50 years. In this brief time, however, these diseases and their allied arteriosclerosis have become the major clinical problem in this country. South Carolina physicians are made all more acutely aware of this fact as they daily observe the effects of hypertensive disease in our Negro population.

Various ideas on the treatment of hypertension have come and gone. Disregard of the condition, salt restriction, protein restriction, salt and protein restriction, the rice diet, garlic, melon seeds, adrenalectomy, sympathectomies of various sorts, psychotherapy, and the vasodepressor drugs have all had or now have their advocates. Difficulties that arise in evaluating any form of treatment include the great variation in the progression of the disease, its long benign and uncomplicated course in many individuals and the rapidly fatal course in certain groups such as young men. Not often recognized is the variable of the personality of the physician behind the pill. This last factor is of an importance almost equal to the personality of the patient behind the disease in determining how well or how badly individuals with chronic diseases may do. The interest, understanding, dominance of the doctor, the ability to inspire confidence and to convert patients to an altered way of life, indeed, to lead patients in their management of a chronic disease is often more important than minor variations in dosage schedule, drugs, or diet. Here lies a problem in the evaluation of even "double blind" studies and is almost certainly the reason why a group of doctors repeating in exact detail methods of treatment which have been reported as successful may not be able to substantiate the findings of the original forceful innovator of a new mode of

therapy. This is true even with all conscientious attempts to avoid such factors. The "art of medicine" is often unrecognized even by its practitioner.

Hypertension like diabetes is not a disease to be cured, but rather one to be controlled. It is more difficult to control than diabetes in many ways, and the use of the more potent ganglionic blocking agents in particular is as difficult or more difficult than the use of insulin. Its dietotherapy demands a less palatable diet too. Advertisements and circulars, television programs, seminars and articles are constantly bringing the message that various drugs effectively lower blood pressure or control various manifestations of long standing hypertension. Yet casual conversation with many physicians elicits almost universal disappointment with the results they achieve with the vasodepressor agents. The elderly patient with benign essential hypertension will usually run a long uncomplicated course with the simplest of therapy or no therapy at all. However, in the more severe cases where treatment is necessary the greatest difficulties arise. Possibly the answer to the successful control of this form of the disease by any regimen lies in appreciation by the physician of the importance of his own role and an accurate appraisal of each patient with the disease and of that patients' abilities to comprehend and follow the prescribed regimen as well as the meticulous attention to detail characteristic of the best physicians.

Cheves Smythe, M. D.

THE DOSE OF INFLUENZA VACCINE

When the public prints were raging with the horrors of impending Asian influenza, and the vaccine supply was too little (and maybe too late), physicians were told that they might stretch the available quantity of vaccine by using intradermal injection of one tenth the amount recommended for subcutaneous injection, and that the results would be as good

in terms of immunity. This idea was accepted and practitioners went confidently about their ways, expecting good results.

Now the bubble of confidence seems to be burst by a shaft recently loosed which carries the message that things weren't as they seemed to be. Subcutaneous injection, the message says, stimulated antibody titers in 22 of 28 persons, while of the 22 people taking the intracutaneous injection only 8 developed antibody titers, and those at a lower level.

These studies were made with the "new" vaccine, and perhaps an even more potent variety might give better results, but even so, it appears doubtful that intracutaneous injection can be relied on, since the practical limitation of the amount injectable would seem to discourage this approach. Even though a stronger vaccine is available, the number of units injected into the skin would be small.

J.A.M.A. 165: 1687, Nov. 30, 1957.

THE FORAND BILL

This bill calls for the expansion of the Social Security Act into the medical and hospital care field. It has been referred to the House Ways and Means Committee, of which Mr. Forand is a member, and has strong backing of the AFL-CIO.

HR 9467 proposes that the federal government, through the Social Security System, pay the cost of hospital, nursing home, and surgical service for persons eligible for old-age and survivors insurance benefits.

This socialized medicine proposal for a large and growing segment of the American people is essentially the same as that of 1941-51, when the Wagner-Murray-Dingell bills called for "National Compulsory Health Insurance," except that it applies to a smaller segment at this time. The enactment of this legislation will permit the federal government to withdraw Social Security taxes on a compulsory basis from almost the entire working population and use those taxes to reimburse hospitals and physicians for services rendered to all persons eligible to receive old age and survivors benefits. It is estimated that at present there are approximately twelve to thirteen million persons in these categories.

The American Medical Association has re-

peatedly opposed compulsory health insurance and is unequivocally opposed to this new version.

The pressure for expansion of the Social Security System into the area of health and medical care benefits is formidable. Congressman Forand, Democrat, Rhode Island, has expressed his gratitude to the AFL-CIO for assistance in framing the bill. Many members of Congress will inevitably support such legislation because of pressure from their constituents, particularly those over 65, who will be favorably impressed by the immediate benefits to be gained. Social Security has been difficult to contain because of its intrinsic political appeal.

On the other hand, the strength of the opposition to this precipitate and revolutionary proposal is also great. Allied with the American Medical Association in its opposition are the American Farm Bureau Federation, the National Retailers Federation, the United States Chamber of Commerce, the life insurance and health insurance industries, the National Association of Manufacturers and innumerable other organizations and individual citizens who are opposed to government intervention into medical and other private affairs. These organizations and individuals will again indicate their strong opposition to the nationalization of hospitals and medicine, just as they did in 1950 if the matter is brought to their attention. This process of alerting medicine's friends is now under way nationally. *State and county medical societies can immediately take similar action with state and local affiliated bodies of national organizations and other influential groups, whose policies are such that they would be expected to oppose socialized medicine.*

It is anticipated that Secretary Folsom of the Department of Health, Education and Welfare will recommend that the Administration oppose the Forand Bill.

Secretaries Letter, A. M. A.

THE MEDICAL COLLEGE HOSPITAL

PHYSICIANS SHOULD SUPPORT ITS
REQUEST FOR ADEQUATE APPROPRIATION

At this time the various state institutions are placing their requirements before the

State Budget and Control Board. These will include requests for extension of present services as well as for the establishment of new ones. Many of these have great merit and would, no doubt, be of value to the state. On the other hand, regardless of their worth, prior consideration should be given to supporting those projects to which the state is already committed.

Among these is the Medical College Hospital. Upon the recommendation of the medical profession this was established, in conjunction with the Medical College, to promote medical education and to provide a center for medical skills and facilities which for economic and other reasons are not commonly available in community hospitals. It is a costly undertaking, but the expense is justified as a sound investment in improving the standards of medical care in the state. For the Medical College Hospital to serve the purposes for which it is intended and limit its admissions to patients referred for strictly medical purposes, it must receive the support of a legislative appropriation adequate for plant maintenance and professional salaries. The alternative would be for it to seek financial support from that field of patient care commonly considered the province of the community hospitals. This would seriously disturb the established hospital practices in the state, as community hospitals, dependent almost solely on income from patients, could not offer the same physical advantages as the state-supported College Hospital without greatly increasing their rates. Also, inadequate support by the state would tend to make the Medical College Hospital adopt professional and institutional policies, which, in the long run, would impair its usefulness.

While adequate financial support by the state is essential, of still greater importance to the proper development of the medical College Hospital, is support by the physicians of the state. Their use of it as a referral center will determine the success of the undertaking. It is recognized that time will be required to change well-established traffic patterns which existed prior to the opening of the Medical College Hospital. To the individual physician there are obvious advantages in having a well-

established referral center within the borders of the state.

The medical profession should assist the Medical College Hospital in obtaining from the Legislature adequate financial support for maintenance and expansion. The South Carolina Medical Association approved the establishment of the Medical College Hospital. Continued support by the Association could be effectively expressed by formal approval of its policies and plans, particularly in connection with its annual budget presentation. This could be best accomplished by the establishment of a Standing Committee of the State Association to serve as a liaison between the State Association and the Medical College. For the present, the most effective way for the medical profession to support the Medical College Hospital in its applications for an adequate appropriation is through the effort of physicians as individuals and in small groups. Its importance should be explained to members of the Senate and House.

In order for the Medical College Hospital to continue to develop properly and serve the purposes for which it is intended, it must have not only the approval but also the full backing of the physicians of the state.

William H. Prioleau, M. D.

SOCIAL SECURITY SAYS: "There is no provision in the law which permits a refund of social security taxes paid if you do not have enough work under the law to get social security payments."

In Other Words: Your uncollectable "contribution" goes to charity, and not "insurance."

SOCIAL SECURITY SAYS: "A woman who becomes entitled to benefits based on her own earnings and also the wife's benefits on the earnings of her husband would receive no more than the larger of the two amounts. A child who becomes entitled to child's benefits based on earnings of both his father and mother would not receive both payments."

In Other Words: Double social security taxes paid by one family do not produce benefits for each member paying the taxes. A part of the taxes go to "charity."

SOCIAL SECURITY SAYS: "People are taxed only once for Social Security."

In Other Words: The employer who must pay his share of the social security tax for each of his employees increases the price of his product or service to cover this additional cost of doing business. Everybody pays this increase as a hidden "sales tax."



LIGHTEN OUR DARKNESS

What hardworking, nightcrawling practitioner has not craned his neck, bumped the curb, driven into the ditch or otherwise inconvenienced himself trying — while accompanying himself with muttered curses—to find the house number that isn't there, or is so well concealed that not even Diogenes' lantern could locate it. Here pictured above is hope for all of us who stumble about in the dark, a star, a beacon, a veritable Pharos, a genuinely large well-illuminated number for which we can aim as straight as the fly flies to molasses. If the Congress would leave fussing over hypothetical reforms and pass an act requiring every householder to buy himself a proper nightlight number, how sweet would be the solace to the wandering doctor.

But there would be a catch in it. Who would make the man turn the darn thing on?

EXCERPTS FROM A REPORT ON ACTIONS OF THE HOUSE OF DELEGATES AMERICAN MEDICAL ASSOCIATION DECEMBER 3-6, 1957 PHILADELPHIA

Dr. Cecil W. Clark of Cameron, Louisiana, was named 1957 General Practitioner of the Year after his selection by a special committee of the Board of Trustees for outstanding community service. Dr. Clark, 33-year-old country doctor who was a medical hero during Hurricane Audrey last June, was present at the meeting to receive the gold medal which goes with the annual award.

Speaking at the opening session on Tuesday, Dr. David B. Allman of Atlantic City, A. M. A. President, called for "more freedom, not less, in America and in the medical profession." Dr. Allman urged the delegates to embark on local action campaigns to enlist full community support in opposition to the Forand Bill, a pending Congressional proposal which would provide hospital and surgical benefits for persons who are receiving or are eligible for Social Security retirement and survivorship payments. The Forand Bill, he said, is "cut from the same cloth" as national compulsory health insurance and "emanates from the same minds."

Fluoridation of Water

In settling the most controversial issue at the Philadelphia meeting, the House of Delegates approved a joint report of the Council on Drugs and the Council on Foods and Nutrition which endorsed the fluoridation of public water supplies as a safe and practical method of reducing the incidence of dental caries during childhood. The 27-page report on the study which was directed by the House at the Seattle Clinical Meeting one year ago contained these conclusions:

"1. Fluoridation of public water supplies so as to provide the approximate equivalent of 1 ppm of fluorine in drinking water has been established as a method for reducing dental caries in children up to

BEWARE... TAKE CARE...

Not since the days of Oscar Ewing has the medical profession been faced with a more socialistic bill than H.R. 9467. (*Forand Bill*)

Introduced by a Rhode Island Representative, if enacted it will give free hospitalization to all Social Security recipients.

It provides for a total of 120 days free hospitalization in a general hospital or nursing home per year, for an estimated 12,000,000 people.

The Hospitals who will benefit by it are very interested.

You, the Doctor, should be also, but mainly in its DEFEAT.

You, the Doctor, should BEWARE.

For another slice of your practice is being surreptitiously removed.

TAKE CARE... write or better still call your Senators and Representatives. voice your objection.

Delaying now means Socialized Medicine and Slavery Tomorrow.

From *The Worcestre Medical News*

10 years of age. In localities with warm climates, or where for other reasons the ingestion of water or other sources of considerable fluorine content is high, a lower concentration of fluoride is advisable. On the basis of the available evidence, it appears that this method decreases the incidence of caries during childhood. The evidence from Colorado Springs indicates as well a reduction in the rate of dental caries up to at least 44 years of age.

"2. No evidence has been found since the 1951 statement by the Councils to prove that continuous ingestion of water containing the equivalent of approximately 1 ppm of fluorine for long periods by large segments of the population is harmful to the general health. Mottling of the tooth enamel (dental fluorosis) associated with this level of fluoridation is minimal. The importance of this mottling is outweighed by the caries-inhibiting effect of the fluoride.

"3. Fluoridation of public water supplies should be regarded as a prophylactic measure for reducing tooth decay at the community level and is applicable where the water supply contains less than the equivalent of 1 ppm of fluorine."

Free Choice of Physician

One Council opinion, issued in 1927 and reaffirmed in Philadelphia, stated that the contract practice of medicine would be determined to be unethical if "a reasonable degree of free choice of physician is denied those cared for in a community where other competent physicians are readily available." The resolution also cited a Council opinion, published in the October 19, 1957, issue of *The Journal of the A. M. A.*, which stated that the basic ethical concepts in both the 1955 and 1957 editions of the *Principles of Medical Ethics* are identical in spite of changes in format and wording. This opinion added that "no opinion or report of the Council interpreting these basic principles which were in effect at the time of the revision has been rescinded by the adoption of the 1957 principles."

In another action related to the issue of free choice, the House adopted a resolution condemning the current attitude and method of operation of the United Mine Workers of America Welfare and Retirement Fund "as tending to lower the quality and availability of medical and hospital care to its beneficiaries."

The Heller Report

Acting on the report of the Committee to Study the Heller Report on Organization of the American Medical Association, the House reached the following decisions on ten specific recommendations:

1. The office of Vice-President will be continued as an elective office.

2. The offices of Secretary and Treasurer will be combined into one office to be known as Secretary-Treasurer, and that officer will be selected by the Board of Trustees from one of its number.

3. The duties of the Secretary-Treasurer will be separated from those of the Executive Vice-President.

4. The office of General Manager will be dis-

continued, and the new office of Executive Vice-President will be established. The latter, appointed by the Board of Trustees, will be the chief staff executive of the Association.

5. The Council on Medical Education and Hospitals and the Council on Medical Service will continue as standing committees of the House of Delegates, but their administrative direction will be vested in the Executive Vice-President.

6. The voting members of the Board of Trustees will be limited to eleven—the nine elected Trustees, the President and the President-Elect. The Vice-President and the Speaker and Vice-Speaker of the House of Delegates will attend all Board meetings, including executive sessions, with the right of discussion but without the right to vote.

7. The House disapproved of the proposal to elect the Trustees from each of nine physician-population regions.

8. The office of Assistant Secretary will be discontinued, and a new office of Assistant Executive Vice-President will be established.

9. The Committee on Federal Medical Services will be retained as a committee of the Council on Medical Service and will not become a part of the Council on National Defense.

10. The Speaker of the House will appoint a joint and continuing committee of six members, three from the Board of Trustees and three from the House, to redefine the central concept of A. M. A. objectives and basic programs, consider the placing of greater emphasis on scientific activities, take the lead in creating more cohesion among national medical societies and study socio-economic problems.

The accepted recommendations were referred to the Council on Constitution and By-laws with a request to draft appropriate amendments for consideration by the House at the 1958 annual meeting in San Francisco.

The Forand Bill

The House condemned the Forand Bill as undesirable legislation, approved the firm position taken in opposition to it and expressed satisfaction that the Board of Trustees has appointed a special task force which is taking action to defeat the bill. In a related action, giving strong approval to Dr. Allman's address at the opening session, the House adopted a statement which said:

"It is particularly timely that our President has so forcefully sounded the clarion call to the entire profession for emergency action. With complete unity, definition and singleness of purpose, closing of ranks with all age groups and elements of our organization we must at this time stand and be counted. Thus we can exert the physician's influence in every possible direction against invasion of our basic American liberties in the form of proposed legislation alleged to compulsory insure one segment of the population against health hazards at the expense of all."

A set of "Guiding Principles for an Occupational Health Program in a Hospital Employee Group" was approved by the House.

Asian Influenza Vaccine

The House considered three resolutions dealing with the Asian influenza immunization program and then adopted a substitute resolution calling attention to "certain inadequacies and confusions in the distribution of vaccines" and directing the Board of Trustees to seek conferences through existing committees "with a view to establishing a code of practices regulating the future distribution of important therapeutic products, so that the best interest of all the people may be served." The resolution pointed out that the American Medical Association already has a joint committee with the American Pharmaceutical Association and the National Association of Retail Druggists, in addition to a liaison committee with the Drug Manufacturers Association.

Medical Rating of Physical Impairment

The House accepted a 115-page "Guide to the Evaluation of Permanent Impairment of the Extremities and Back" which was developed by the Committee on Medical Rating of Physical Impairment as the first in a projected series of guides.

The House also endorsed a suggestion that the Committee on Federal Medical Services sponsor a national conference on *veterans' medical care* during 1958;

Asked the Board of Trustees to study the feasibility of having the Association finance a thorough investigation of the *Social Security* system by a qualified private agency;

Suggested that physicians and their friends make a vigorous effort to obtain Congressional enactment of the *Jenkins-Keogh Bills*.

NEWS

DR. KENNETH LYNCH HONORED AGAIN

Dr. Kenneth M. Lynch, president of the Medical College of South Carolina received on November 13 the Southern Medical Association's Distinguished Service Award. It is the Association's highest honor, presented for outstanding contributions.

Dr. Lynch was previously honored in September when he was named to the 12-member National Advisory Neurological Diseases and Blindness Council for a four-year term. The council advises the Surgeon General and the National Institute of Neurological Diseases and Blindness in the awarding of medical grants.

Dr. Lynch's efforts resulted in the construction of the Medical College Hospital two years ago. It is now recognized as one of the medical centers of the



KENNETH M. LYNCH, M. D., D. Sc., LL. D.

President and Dean of the Faculty, Medical College of South Carolina, Charleston, South Carolina.

nation.

Dr. Lynch is a pathologist and is a recognized research scientist and medical administrator. He was graduated from the University of Texas Medical School in 1910. Honorary degrees have been awarded him by the University of South Carolina, the College of Charleston and Clemson College.

He has been awarded the Gold Medal and Research Medal of the American and Southern Medical Associations. In addition he has been granted a number of research grants and has been instrumental in obtaining many others.

He came to Charleston in 1913 as professor of pathology at the Medical College and pathologist for Roper Hospital. Earlier medical work was done at the University of Pennsylvania and Philadelphia General Hospital. He became vice dean of the Medical College in 1936, dean in 1944, and president in 1949.

He has served as consulting pathologist for the Veterans Administration and on the editorial boards of several medical journals. He is the author of several books and many scientific articles. He has conducted extensive research in the fields of human protozoology, experimental cancer and industrial dust diseases.

Offices he has held include secretary of the Pan-American Medical College; president, American Society of Clinical Pathologists; president, American Society of Tropical Medicine and Hygiene; and vice president of the American Medical Association, as well as the presidency of the South Carolina Medical Association.

MEDICAL SOCIETY OF SOUTH CAROLINA

The Medical Society of South Carolina (Charleston) reached its 168th year in 1957. Its annual meeting was held on November 21 at the South Carolina Hall in Charleston. There was a considerable attendance and a pleasant dinner was served.

Dr. Robert Wilson was re-elected president. Dr. George Durst was elected vice-president, and Dr. F. M. Ball was re-elected secretary and treasurer. Various matters having to do with The Roper Hospital were discussed and the following papers were read—all by title:

1. High Mortality and Low Virility Rates in Radiologists, by Dr. Samuel Lippincott.
2. Technique of Surgical Pelvic Examination in Contrast to the Gynecological, Urological, and Social Approach, by Dr. William H. Prioleau.
3. Investment Planning for your Second Million, by Dr. Harold Pettit.
4. Lawyers I have Loved, by Dr. W. A. Smith.
5. Use and Abuse of Royal Jelly, by Dr. John Cuttino.
6. The Specialist in Death, by Dr. Harold Pratt-Thomas.
7. Parliamentary Procedures on Bed and Table, by Dr. Arthur Rivers.
8. Dermatological Emergencies, by Dr. John Van de Erve.
9. My Race with Sputnik, by Dr. Edward Parker.

DR. WILLIAM J. BEASLEY

Under the title "Portrait of a Doctor", the *Hartsville Messenger* describes a much beloved 78 year old practitioner who still maintains his very small office in The Corner Drug Store, and still makes house calls to his patients.

Born in 1879, he studied medicine for a time at the University of Virginia and then graduated from the Medical College of South Carolina, interning at Roper Hospital. He opened his office in 1905.

After the horse and buggy days, the doctor acquired an old model T Ford, and friends say that you could always tell when Dr. Beasley was coming, as the back end of the Ford looked as if there was a bale of hay burning inside (it used so much oil).

An excellent philosopher, with a photographic memory, Dr. Beasley made the outstanding score of 100 on his final medical examination. Surpassing his class in English, he was also adept at the Romance languages, and at one point in his life subscribed to a French newspaper and could read it as the average American reads his hometown newspaper. He also taught a Latin Class.

His charges to persons not able to afford a physician's care were marked up on the 'experience' side of the ledger, and these philanthropic measures have made more friends for Dr. Beasley than any other factor in his remarkable lifetime of service.

In commenting on his early days as a doctor, it would seem that his practice involved a little of every-

thing. He performed surgery, delivered babies, and even pulled teeth (the latter bringing screams of 'bloody murder' from his patients, as he was not as proficient in the art of dentistry as he was in other aspects of medical work).

Roads were rough, and the good-natured doctor used a horse and buggy for his early calls. Sometimes working into the wee hours of the night, he'd leave a patient's home, climb into his buggy and fall fast asleep. His horse, "Black Beauty," would unerringly find the way home, however.

One of the finest things said about the physician were these words: "I've never heard him say an ugly word about any person whatsoever. Nor have I ever heard him say anything about a competitor. If he says anything about anyone, you can be sure it will be something to build character—never to tear it down."

William J. Beasley, summing it all up, is quite a doctor, quite a philanthropist, quite a servant to mankind.

Dr. Victor Branford of Dillon has been elected president of the Pee Dee Medical Association for 1958.

At the Tenth Annual Meeting of the South Carolina Obstetrical and Gynecological Society, held in Columbia on November 2 and 3 in conjunction with the Georgia Obstetrical and Gynecological Society, Dr. Herbert Blake was succeeded by Dr. Lawrence Hester, Jr., as president. Papers were given by several South Carolina members and guests, Dr. Hugo Ris and Dr. Edwin Bradley of Greenville, Dr. Rowland Zeigler of Florence, and Dr. Harry Temple of Charleston.

The Coastal Medical Society met at Walterboro on November 21. Dr. Ford A. Rivers of Charleston spoke on Congenital Heart Lesions.

Dr. James R. Cain, native of Charleston, has been named director of the pathology laboratory at Spartanburg General Hospital.

Dr. Cain has assumed his official duties at the hospital.

He attended Charleston City Schools, the College of Charleston, and graduated from the Medical College of South Carolina in 1947.

Dr. Cain interned at Kansas City, Mo., then served 38 months residency in pathology at the Medical College of South Carolina, his residency ending in 1951.

He spent two years in the Armed Forces, after which he settled in Atlanta, Ga. In Atlanta, he had further training in pathology and practiced pathology and clinical pathology at the Crawford W. Long Memorial Hospital, Grady Memorial Hospital and St. Joseph Infirmary all in Atlanta.

Dr. Martin D. Young, director of the Laboratory of

Tropical Diseases, U. S. Public Health Service at the South Carolina State Hospital, was on the staff of a training course in malaria eradication techniques held in Guatemala and El Salvador. The course was offered under the auspices of the Pan American Sanitary Bureau.

Dr. Norton L. Williams, associate in psychiatry at the Medical College of South Carolina presented a paper at the annual convention of the Southern Medical Association in Miami.

The paper was titled "The Role of Psychotherapy in Modern Medicine."

SALK VACCINE

New statistics produced by the National Health Survey indicate that 45,000,000 persons under 40 years of age still have not received Salk poliomyelitis vaccine. The new data, based on information obtained in household interviews, also shows the following: 5,000,000 under 40 received one injection, in contrast to earlier estimates of 17,000,000; 25,000,000 have received two shots, instead of the earlier estimate of 28,000,000; the number receiving the full three shots has increased from an estimated 28,000,000 to 34,000,000.

Commenting on the new Statistics, Surgeon General says:

"It is encouraging to find that the number of persons with maximum protection is greater than had previously been estimated. However, the fact that there are still an estimated 45 million—15 million children and 30 million adults under 40—with no protection is a matter of grave concern. . . . The present supply of vaccine is ample and the manufacturers can produce additional vaccine in pace with the need. Unvaccinated persons who become crippled by paralytic polio in the future will suffer a dual tragedy: that of having a disability and of knowing that, in all probability, it could have been prevented by the simple and painless precaution of vaccination."

Last January the American Medical Association initiated the nationwide campaign to promote use of Salk vaccine, after a surplus started piling up and manufacturers cut their production. Subsequently, the surplus was wiped out and scattered shortages appeared. Now, however, supplies are adequate and manufacturers are prepared to step up their future output in line with demand.

A.M.A. Washington Letter

SENATE COMMITTEE MAY INCLUDE JENKINS-KEOGH IN OMNIBUS BILL

The Jenkins-Keogh plan for tax deferment on retirement funds paid by the self-employed may be made a part of an omnibus tax relief bill for small business. The idea is under consideration by a tax subcommittee of the Senate Small Business Committee which is continuing regional hearings on gen-

eral tax problems for the small businessman and the self-employed. It is planned to have a committee bill reported out and ready for floor action by late January.

While tax measures are supposed to originate in the House, the omnibus bill under study could be attached as an amendment to any House-passed tax bill that comes to the Senate. After passage by the Senate, it would go to conference if the House asked for such conference. No further hearings would be required under the procedure. However, by then, the House Ways and Means Committee would have covered the ground in its general tax hearings opening January 7 and running through February 7.

The American Thrift Assembly is pushing for enactment of Jenkins-Keogh legislation in the interest of 10 million self-employed. Unlike employees of corporations and associations, they cannot set aside retirement funds with a deferment of taxes.

DRS. GIBBES, WINSLOW OPEN PEDIATRICS OFFICE

Dr. Robert W. Gibbs and Dr. Francis E. Winslow, Jr., have announced the opening of their office for the practice of pediatrics at 1517 Hampton Street, Columbia.

Dr. Gibbs attended the Columbia schools and graduated from the University of South Carolina. He received his degree in medicine from Duke University. He took his internship and residency training in pediatrics at University Hospital in Baltimore, Md. Dr. Gibbs is married and lives at 1020 Bull St., his wife being the former Carolyn Williams of Frederick, Md.

Dr. Winslow of Rocky Mount, N. C., was graduated from Episcopal High School, Alexandria, Va., and received his pre-medical education and A. B. degrees at Harvard University and the University of North Carolina. At North Carolina he was a member of Phi Beta Kappa and Delta Kappa Epsilon fraternities. He received his medical education at Duke University School of Medicine where he was a member of Alpha Omega Alpha society. He interned and completed his pediatric training at University Hospital, Baltimore, Md. Dr. Winslow served almost 4 years in the Navy.

Dr. William S. Hall, superintendent, South Carolina State Hospital, is president of the recently organized South Carolina District branch of the American Psychiatric Association.

Other officers: vice president, Dr. J. J. Cleckley, Department of Neuropsychiatry, Medical College of South Carolina, secretary and treasurer, Dr. Joe E. Freed, chief, women's service, Columbia Division, S. C. State Hospital; councilors, Dr. W. P. Beckman, state director of mental health, Columbia and Dr. J. J. Nannarello, private practicing psychiatrist of Greenville.

This first formal meeting was joint with the Southeastern Society of Neurology and Psychiatry. Speaker for the scientific program was Dr. A. S. Alison, visiting

professor of neurology from England, who is spending several weeks as a clinical lecturer at the Medical College in Charleston.

At the annual Seaboard Railroad Surgeons' convention held in October in Richmond, Va., Dr. A. W. Lowman, of Denmark, was elected first vice president of the association. Dr. Lowman has been a member of the Seaboard railroad medical staff since 1939.

Dr. Francis Nolan McCorkle, Jr., began the practice of medicine in Camden October 15th.

Dr. McCorkle is a native of Camden and graduated from the Camden High School in 1943. Soon after graduation he entered the U. S. Armed Forces, and is a combat veteran of World War II, having served with the 45th Infantry Division in Germany.

After being discharged from the service in 1946, Dr. McCorkle entered the University of South Carolina and was graduated from that institution in 1949 with a B. S. degree. He was graduated from the Medical College of South Carolina in 1953. He interned at the Cincinnati General Hospital, affiliated with the University of Cincinnati School of Medicine.

During the past three years, Dr. McCorkle was Resident Physician in Internal Medicine at the Medical College Center and Roper Hospitals, Charleston.

This past year, Dr. McCorkle was Staff Physician at the Heart Clinic of the Medical College of South Carolina, having been awarded a Fellowship in Cardiology by the National Heart Institute, Bethesda, Maryland. He was a member of the Diagnostic Heart Catheterization Team, and Heart Surgical Team at the Medical College of South Carolina. He was also Senior Resident in Internal Medicine at the Medical Center Hospital.

Dr. McCorkle's practice will be limited to cardiology and internal medicine, including allergy. His office will be located in the new Medical Building in Burndale Shopping Center.

A legislative - governor's committee headed by Rep. May of Aiken County on October 31 heard medical experts urge a centralized nursing home with special equipment to care for dying cancer patients who are poor.

Mrs. Nettie Dickerson, Columbia nurse, told the committee that little more than custodial care could be given in regional nursing homes, the alternative to a centralized location.

Dr. Leland Brannon, head of the cancer clinic at Columbia Hospital, said he was "convinced of the need of . . . a centralized hospital or nursing home where adequate care can be given these unfortunates."

Dr. Brannon said there are terminal cancer patients in "all counties across the state."

"Caring for them is a specialty. They need surgery, x-ray treatment and special medical treatment. Some places can't give x-ray therapy and do not have neuro-

surgeons to perform pain-relieving operations," he said.

Dr. Brannon suggested also that in a central location experimental work could be done under financial grants available for such projects.

Dr. Frank Geiger, of the State Health Dept.'s Division of Chronic Diseases, agreed that a centralized facility would be preferable.

Arthur Rivers, director of the State Welfare Dept., said he thought there was "a good possibility that welfare payments up to \$58 a month could be continued to eligible patients."

PHS ADVISES AGAINST COMMUNITY-WIDE TB X-RAY CAMPAIGNS

Public Health Service, acting on advice of a committee of medical and public health leaders called in to re-evaluate recent changes in the nature of the tuberculosis problem, is recommending against community-wide chest x-ray campaigns for detection of TB. Instead PHS recommends that communities use tuberculin skin testing as a first step in case-finding, followed up with x-ray examinations for those with positive reactions.

The service suggests, that x-ray examinations be continued on selective groups, those with greatest risk, such as persons confined to hospitals and other institutions, low-income groups, migrant workers and people known to have been exposed to the disease. It was emphasized that groups to be given x-rays should be selected locally, with the choice based on the local tuberculosis problem, the expected yield of new cases and the adequacy of diagnostic and treatment facilities and of follow-up services.

One factor given consideration in reaching the decision, PHS says, is "the problem of low-level radiation exposure from x-rays." To further reduce radiation exposure, both of the operators and the public, PHS urges periodic inspection of all x-ray equipment, and installation of further protective devices where indicated.

Of the new tuberculosis picture, PHS says: "In the last 15 years . . . the tuberculosis problem has changed radically. Some areas of the country are now practically free of active cases of the disease. In other areas, tuberculosis continues to be a serious problem, particularly among certain groups. While the number of active cases has declined almost 30 percent in the last 5 years, it is estimated that there are still about 250,000 persons with active tuberculosis in the United States today."

The American College of Physicians named Dr. Peter Christopher Gazes, Charleston, as a Fellow of the College at the November 9-10, 1957 meeting of the Board of Regents at the College headquarters in Philadelphia, Pa.

The following physicians from South Carolina were named as Associates of the College:

Columbia: Dr. Hugh Hammond Dubose, Dr. James Cain Vardell, Jr.

Florence: Dr. Myers Hampton Hicks.

Greenville: Dr. John Crawford Muller, Dr. William Watkins Pryor, Dr. Robert Richard Stanley.

The largest meeting in 51 years of the history of the Southern Medical Association was held in Miami Beach, November 11-14.

The unofficial registration total was 5,761 of which 3,133 were physicians.

At the conclusion of the meeting Dr. W. Kelly West of Oklahoma City, Oklahoma, was installed as President succeeding Dr. J. P. Culpepper, Jr., Hattiesburg, Mississippi. Other officers elected at this meeting were:

President-Elect—Dr. Milford O. Rouse, Dallas, Texas

First Vice-President—Dr. Edwin H. Lawson, New Orleans, La.

Second Vice-President—Dr. Donald F. Marion, Miami, Florida

Elections by the Council included Council Chairman, Dr. Fount Richardson, Fayetteville, Arkansas; Council Vice-Chairman, Dr. Harry Lee Claud, Washington, D. C.; Member of Board of Trustees, Dr. J. P. Culpepper, Jr., Hattiesburg, Mississippi.

Recipient of the Association's Research Medal was Dr. Joseph M. Hill of Dallas, Texas. Dr. Hill is the sixteenth winner of this outstanding award for scientific research which was established in 1912.

Dr. Kenneth M. Lynch, President and Dean of the Faculty of the Medical College of South Carolina, received the Association's Distinguished Service Award.

The future schedule of meetings is as follows:

1958—New Orleans, Louisiana, November 3-6

1959—Atlanta, Georgia, November 9-12

1960—Baltimore, Maryland, November 14-17

1961—Dallas, Texas, November 13-16

1962—Miami Beach, Florida

AMA'S REASONS FOR OPPOSING HOSPITALIZATION AT AGE 65 UNDER OASI

Announcing that it will "strongly oppose" the Forand bill for hospitalization and medical benefits under social security, the American Medical Association has explained its reasons. The Forand bill is H. R. 9467, introduced late last session. It offers 60 days of hospitalization, plus surgical benefits, and an additional 60 days of nursing home care, to all social security beneficiaries 65 years of age and older, and the same benefits to their survivors and dependents. Says Dr. David E. Allman of Atlantic City, AMA president:

"This proposal is clearly 'socialized medicine' for a segment of the American people. Enactment

would permit the federal government to withdraw social security taxes on a compulsory basis from almost the entire working population and use those taxes to reimburse hospitals and physicians for services rendered to all persons eligible to receive old age and survivors benefits. The American Medical Association has repeatedly opposed compulsory health insurance and is unequivocally opposed to this new version."

A task force of the Board of Trustees now is making an intensive research study of the health status of the population 65 years of age and over. Heading this special group is Dr. George M. Fister of Ogden, Utah, under whose direction Walter Polner (Ph. D.) has been assigned to gather information on extent of the problem, economic resources of those affected, contributions from public assistance, relationship of the aged persons to others in the family group, incidence of hospitalization and illness by age groups, and growth within the last 10 years of voluntary health insurance for the aged.

Answers obtained to these questions will be the basis of AMA's testimony when the bill comes up in Congress next year and of the Association's educational efforts in behalf of the public.

Solution to the problem, Dr. Fister maintains, is not a compulsory federal program but the extension to older persons of voluntary health insurance, which has such a remarkable record of service. Comments Dr. Fister:

"The A. M. A. has supported and promoted voluntary health insurance and other voluntary measures designed to promote individual and family economic security and responsibility. Progress in this direction has been phenomenal. Let's not take hasty action. . . This picture is too complex. What we must do is study the problem carefully. Government intervention would be fatal."

Dr. Fister noted that "the strength of the opposition to this precipitate and revolutionary proposal is great." He said that allied with the AMA were the American Farm Bureau Federation, the National Retailers Federation, the U. S. Chamber of Commerce, life and health insurance industries, the National Association of Manufacturers and "innumerable other organizations and individual citizens who are opposed to government intervention into medical and other private affairs."

Dr. Katherine MacInnis of Columbia was re-elected secretary-treasurer of the Southeastern Allergy Association at its last meeting.

Dr. Malcolm Dantzler, Charleston, has passed his examination for certification as a member of the American Board of Preventive Medicine and Public Health.

ANNOUNCEMENTS

ATLANTA ASSEMBLY

The Atlanta Graduate Medical Assembly will be held on February 17 - 19, 1958 at the Atlanta Biltmore Hotel. The speaking faculty will include Drs. Paul B. Beeson, G. E. Burch, Philip K. Bondy, Michael E. DeBakey, Robert P. Glover, Bayard Carter, John A. Wall, Robert B. Heath, Raymond D. Adams, Bronson S. Ray, Hans Popper, Sydney S. Gellis, Harold O. Peterson, and Edwin L. Prien.

Write to: Atlanta Graduate Medical Assembly, 875 West Peachtree St. N. W., Atlanta, Georgia.

SIXTH Postgraduate Course—DIABETES and BASIC METABOLIC PROBLEMS,

Christopher J. McLoughlin, M. D., Director.

C. Raymond Arp, M. D.; Walter L. Bloom, M. D., Associate Directors.

January 22, 23, 24, 1958. Academy of Medicine, Fulton County Medical Society, Atlanta, Georgia.

FEES: \$40 for the three-day Course for members of the American Diabetes Association; \$75 for non-members. The full fee is payable at the time of filing application for the Course and will be returnable by the Association to any registrant who submits his withdrawal in writing not later than January 10.

The Bureau of Old-Age and Survivors Insurance, Social Security Administration, has announced vacancies for full-time and part-time Medical Consultants in its Division of Disability Operations. The Division is responsible for making determinations of disability under the disability insurance provisions of the Social Security Act. These positions are available in the headquarters offices in Baltimore, Maryland.

The full-time positions are under Civil Service and incumbents will receive all Federal Civil Service benefits such as retirement, life insurance, and vacation and sick leave privileges. The salary range is \$10,065 to \$11,395 a year depending on the individual's qualifications. The salary in part-time positions is paid on a per diem basis.

An article describing in greater detail the basic medical aspects of disability insurance operations under the Social Security Act may be found in the January 15, 1955, issue of the *Journal of the American Medical Association*, pages 270 and 271. Copies of this article are available on request.

These positions, in Baltimore, Maryland, afford excellent opportunities for participation in clinical work and study in the city's nationally recognized hospitals.

Physicians interested in either full-time or part-time positions may write to Dr. Arthur B. Price, Chief Medical Consultant, Division of Disability Operations, 200 West Baltimore Street, Baltimore 1, Maryland, for further information.

DEATHS



DR. ROBERT B. DURHAM

Dr. Robert B. Durham, Columbia surgeon, died at his home, Sleepy Hollow in Lexington County, October 5, 1957.

Dr. Durham, 65, had been ill for several weeks.

A prominent Columbia surgeon, Dr. Durham had practiced medicine in Columbia since 1915 until his retirement two years ago. He had been chief of the surgical staff at the Columbia Hospital of Richland County, Providence Hospital and the South Carolina Baptist Hospital in Columbia.

Dr. Durham was born on February 12, 1892, at Ethridge's Mill in Orangeburg County. He received his early education at schools in Orangeburg County and later attended Eau Claire High School and Columbia High School here.

After his public school education he attended the South Carolina Co-Educational Institute at Edgefield where he was a member of the First Baptist Church. He received his medical degree from the University of Georgia's School of Medicine on May 13, 1913. He first practiced medicine at Perry, S. C., but he had been located in Columbia since 1915.

In June, 1917, he volunteered for service in the United States Army and was commissioned a first lieutenant. He was called into service on August 20, 1917, and sailed for France on September 6, 1917. He served with troops in France for 23 months, first as battalion surgeon in the 101st Infantry and later as commander of the 102nd Ambulance Corps. He was promoted to

the rank of Captain in February, 1919.

While in France he studied at the University of Bordeaux for a year, taking a special course in surgery. He returned to the United States and received his honorable discharge in August, 1920.

Upon his return to Columbia, he immediately resumed the practice of medicine. He then served as medical director of the United States Veterans Bureau in Columbia from the time of its organization until the completion of the Veterans Hospital here. He then resigned since further service with that organization would have required his full time.

Throughout his medical career, his primary interest was surgery, and he served for eight years in the early part of his medical service as assistant to the late Dr. Julius H. Taylor of Columbia. He was a Fellow of the American College of Surgeons.

He had served as vice president, chairman of the board of censors and president of the Columbia Medical Society, and he was president of the South Carolina Medical Association in 1948.

Dr. Durham came from a long line of physicians, his grandfather having been an honor graduate of the University of Pennsylvania in 1859. His father was a doctor, and his late brother, Dr. I. D. Durham, practiced for many years.

DR. HOWARD M. WALKER

Dr. Howard M. Walker, radiologist of Spartanburg, S. C. died at Duke University Hospital in Durham, N. C. on November 26, 1957 after a brief illness. He had practiced radiology in Spartanburg for twenty-five years.

Dr. Walker was born in Killeen, Texas on February 1, 1898. He graduated from the Medical School of Texas Christian University in 1921. He did general practice in Texas for eight years, later practicing in Honduras and Guatemala. Subsequently he was associated with the U. S. Public Health Service in New Orleans, Louisiana. Dr. Walker studied extensively in this country and in Vienna. He was connected with several New York Hospitals; Bellevue, Roosevelt and the New York Lying-In Hospital. Prior to coming to Spartanburg he was associate professor of radiology at Yale University Medical School.

He was an accomplished linguist, speaking Italian, Spanish, French and German fluently.

Dr. Walker was a diplomate of the American Board of Radiology, a Fellow of the International Academy of Medicine, a member of the American College of Radiology and the Radiological Society of North Carolina.

BOOK REVIEWS

CLINICAL CARDIOPULMONARY PHYSIOLOGY, Sponsored by The American College of Chest Physicians, Burgess L. Gordon, M. D., Editor-in-Chief.

Grune and Stratton, New York, 1957. Price: \$15.75.

This book, edited by nine recognized authorities on chest disease, is a compilation of writings of 52 contributors on subjects on which they are recognized specialists.

Discussion includes among other subjects methods of examination and testing of lung function, normal physiology and anatomy of the lungs, impairment of mechanics of respiration, asthma, emphysema, pneumoconioses, and sections on congenital and acquired heart disease, congestive heart failure, and pulmonary circulatory abnormality.

The book is well arranged, and the subject matter is presented in such a way that it is for the most part easily understood by the clinician. It is apparent that effort has been made by the contributors to use a practical approach to the subjects presented, and to consider them from the clinician's point of view.

In some chapters emphasis is placed on procedural techniques and pathologic physiology of disease. In others, discussion of the clinical picture of disorders under consideration is emphasized along with the physiologic approach to diagnosis and treatment.

This volume is useful as a reference for the clinician rather than of interest to the investigator. Techniques presented are those in general use and widely accepted as suitable for clinical application. It is recommended as a worthwhile addition to the library of both medical and surgical clinicians whose interests are in chest disease.

Kelly T. McKee, M. D.

GENERAL UROLOGY. Donald R. Smith, M. D. 1957—Lange Medical Publications—Los Altos, Calif. Price \$4.50.

I have had the pleasure of reviewing *General Urology* by Donald R. Smith. It is a well-prepared commonsense approach for a quick and comprehensive reference of urological diseases.

I find it to be a well-illustrated text, preferable for reference and done in outline form.

Paul W. Sanders, Jr., M. D.

ONE SURGEON'S PRACTICE by Frederick Christopher, M. D., W. B. Saunders Company. Philadelphia 1957.

This is an enjoyable account of the author's experiences as a surgeon and teacher. The 141 page book is divided into 14 chapters which include the author's opinions concerning the conduct of the surgeon, philosophy pertaining to the field of surgery, and advice to student, trainee, and practicing surgeon based on his 35 years of practice. Much of the book is an autobiography of his own practice.

The purpose of the book is to pass on to others that which the author has learned from experience. Dr. Christopher is now Emeritus Professor of Surgery, Northwestern University Medical School and is well-qualified to write such a book.

Consideration is given to the choice of college,

medical school, internship and residency. Choice of location in which to practice, partnerships, group practices, hospital and society memberships are reviewed. There are valuable suggestions to the young surgeon who is beginning his practice, including proper conduct in the hospital. Age old questions such as "what the terminal cancer patient should be told" are given brief consideration. The importance of proper relations between the surgeon and anesthetist, general practitioner, and internist are stressed. The pitfalls of surgery and the major reasons for most malpractice suits are listed and briefly discussed. All surgeons are encouraged to teach and to write regardless of whether or not they are affiliated with a teaching center. In the latter chapters are recorded the author's personal observations about non-professional activities, surgical fees, the doctor as a witness, and the rewards of the practice of surgery.

The book has merit in that it offers much food for thought. It can be a guide for the trainee and gives the surgeon a chance to compare his own life as a surgeon with that of a man who has been a dedicated surgeon, teacher, and writer.

R. Randolph Bradham, M. D.

A TEXTBOOK OF HISTOLOGY by A. A. Maximow and William Bloom. 7th Edition. W. B. Saunders Co. Philadelphia 1957. Price \$11.00.

The seventh, 1957 edition of "A Textbook of Histology" by Maximow and Bloom was partly written and edited by Professor William Bloom of the University of Chicago. Larger and smaller sections were written by other authors. In the preface Professor Bloom gives credit to thirty-two different investigators and scholars who have assisted in one way or another. Thus, the textbook material presented comes from a broad base of scholarly experience and intellectual power.

The topic "Histology", as taught in medical schools, must introduce the student to a very large amount of material. Further, histology today is growing so rapidly that it may well be said to be "exploding". It has given off, and is giving off, whole new sub-sciences, such as cellular immunology, morphologic hematology, exfoliated cytology, histochemistry, microscopic circulatory physiology, and others. One new direction of

study consists of the electron microscopy of cells and portions of organized tissues. This new edition of the textbook introduces a fairly large amount of material based upon electron microscopy at magnifications up to as much as one hundred thousand diameters. Newer concepts are also based upon phase microscopy, color contrast microscopy, transillumination of living internal organs, tissue culture, cytochemistry and others.

The textbook, as it stands, is a magnificent introduction to many subdivisions of basic approaches to trying to understand the structure of living things. As might be expected, no subject treated is dealt with fully. The bibliographies in the chapters are good, again only as introductions to topics.

Each edition of this book has been famous for the excellence of its illustrations. Some of the older figures drawn by the late Professor Maximow himself are unsurpassed by any in the world. The new edition contains many drawings in color made by Esther Bohlman, who has worked with Professor Bloom for years and has become one of the finest living medical illustrators. The new edition contains a number of colored plates taken from v. Herrath and Abramow. Some of these have not reproduced too well and were of doubtful value in the first place. Some of the older black and white illustrations, carried over from previous editions, show the effects of wear on the printing plates; new plates should be made. The illustrations on page 375 designed to show differences in the structure of different portions of the gastro-intestinal tract are made at much too low magnification. As they stand, they are of almost no use. In general, those illustrations selected to show the distribution of small vessels within organs were poorly selected. The literature contains many excellent illustrations demonstrating significant features of the angioarchitecture, which should go into subsequent editions.

However, small adverse criticisms aside, it is a privilege to point out that this volume is a necessary book as an introduction to scholarly study by those interested in the available and rapidly growing knowledge of the structure and functioning of cells, tissues and organs.

M. L. Knisely, Ph. D.



**TEN POINT PROGRAM
OF THE
SOUTH CAROLINA MEDICAL ASSOCIATION**

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor

the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

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THE 1957 PRINCIPLES OF MEDICAL ETHICS

PREAMBLE—These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions and with the public.

Section 1—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services

only after giving adequate notice. He should not solicit patients.

Section 6—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8—A physician should seek consultation upon request, in doubtful or difficult cases or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

It is my personal impression that boys choose medicine for one or more of three reasons and occasionally go to medical school because of a fourth. The first reason is that they sense the nature of the doctor's relationship and the mystery of it, the good that doctors do, and the respect and affection in which doctors often seem to be held. The second motive is perhaps not precisely a motive but rather a susceptibility or field of interest; it shows in the boy who loves animals, keeps pets, and prefers rambling in the countryside, or a visit to the zoo, to any other use of his time. He is at heart a biologist. He stands transfixed by the contemplation of living things, and, as his mind becomes more mature, he is fascinated by the phenomena and the mysteries of human life. The third motive relates to the power and composure, the prestige, and sometimes the evident ease and wealth of the doctor. Such authority any child can feel without putting it in so many words. Like the primary colors, which are rarely seen in nature unmixed, these motives, combined in one or another individual proportion, seem to me to compose the primary reasons for the choice of a medical career. There is, of course, a fourth reason, but it can hardly claim consideration as a motive. Some boys are so harried by their parents to become doctors that they go to medical school in default of any other tastes or interests strong enough to withstand parental

pressures. When you see such students—and such doctors—you can be sorry for them, but you can regret even more that they have taken a place desired by others who would have brought a deeper interest and a happier devotion to the practice of medicine. I would be sorrier for those who go into medicine against their own will had I not seen examples of the deftness they can use in avenging themselves. One young man I knew, who was forced into studying medicine when he preferred music, completed medical school and then became organist of the Church of Christ, Scientist.

Challenges to Contemporary Medicine. Alan Gregg.

"By and large, I could think of no more deceptively destructive device for throwing away the best potentialities of full time medical education than organizing medical faculties on the basis of group practice. Furthermore, to organize a medical faculty into a form of group practice invites the opposition as well as the jealousy of the practitioners in the community who are not on the faculty. To minimize any misunderstanding, we might add that a substantial increase of group clinics would improve the practice of medicine, and especially surgery, very appreciably. So it is no reflection on group practice to say that its essentials are not the essentials of teaching or research. . . .

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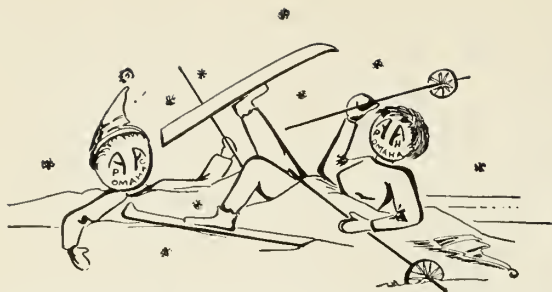


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NUMBER 2

INTERAURICULAR SEPTAL DEFECTS

J. VERNON JEFFORDS,* LAURIE L. BROWN AND EDWARD F. PARKER
Charleston, S. C.

Defects of the interauricular septum are among the more common congenital cardiac anomalies. In a large series of congenital heart defects, Abbott found these septal anomalies to be more numerous than any other type of lesion.¹ Uncomplicated interatrial septal defects have been said to occur in fifteen to twenty per cent of cases of congenital cardiac disease.² In the Cardiac Clinic at the Medical College of South Carolina since January of 1950 there have been seen 95 cases of interauricular septal defect. During the same period there have been seen 103 cases of patent ductus arteriosus and 107 cases of interventricular septal defect. Also during this time there were 55 cases of tetralogy of Fallot. Although these figures are not necessarily a true representation of the relative occurrence of these lesions, this would indicate that interauricular septal defects occur frequently in the potentially cyanotic congenital cardiac disease group.

The prognosis in interatrial septal defect is better than in other congenital cardiac lesions. The average duration of life in a series reviewed by Tinney was 36 years. The causes of death in his series were atrial fibrillation, pulmonary infections, and cardiac decompensation.³ Other authors place the average year of death about 35 years but state that half of the patients live beyond the age of 50. This anomaly can be well tolerated in some pa-

tients to the age of 70 or 80. Bailey states that his group has found no correlation between the size of atrial septal defects and the duration of life.

The embryology involved in the various forms of atrial septal defects is important in the clinical evaluation and surgical treatment of the lesion. The septum primum, presenting itself as a membrane, extends downward from the superior posterior wall of the atrium and divides the atrium into right and left chambers during the fourth week of fetal life. The lower margin of the septum primum has a crescent-shaped defect which is the ostium primum. A second opening, the ostium secundum, appears in the upper portion of the septum primum shortly after its formation. Later, the septum secundum is formed slightly to the right of the septum primum and fuses with it. It leaves an opening, the foramen ovale, which functions as the circulatory pathway in the fetus and is usually closed by the fifth or sixth week after birth. The ostium primum is normally closed in the same period by a downward growth of the septum primum and fusion with the endocardial cushion dividing the auricles. At the age of three months, 98 per cent of normal individuals have a functionally closed foramen ovale. Lewis and his co-workers have classified the defects of the atrial septum as follows:

1. foramen ovale defects,
2. high defects,
3. continuous defects of both foramen ovale and the high septum,
4. low defects.⁴

From the Cardiac Clinic and Departments of Surgery and Anaesthesiology of the Medical College of South Carolina.

*Now practicing in Spartanburg, S. C.

The interauricular septal defect may frequently have incomplete septal rings and may be difficult to find at operation. The closure of low defects by surgical means to date has been very unsatisfactory. All of these low defects have in common evidence of a persistent common atrial ventricular canal. This common canal may remain as no more than a notching of the mitral valve. Closure of these defects may result in injury to the atrioventricular node and result in complete heart block. Repair of this type of defect also may frequently result in damage to the heart valves. Many cases with a significant atrial septal defect have complications manifested by a valvular lesion. The combination of an atrial septal defect with mitral stenosis, known as Lutenbacher's syndrome, has been found to be relatively rare and occurs in only 6 per cent of all atrial septal defects.

The symptoms of an atrial septal defect are extremely variable. There may be no significant symptoms, but when present, the most common are exertional dyspnea, palpitation, easy fatigueability, or weakness. Children are particularly prone to have frequent and severe respiratory infections superimposed upon the pulmonary congestion present in septal defects. Cyanosis and clubbing are usually absent when the predominant shunt is from left to right, but occasionally in later stages cyanosis of some degree may be noted when there is a reversal of flow through the defect. These patients are often underdeveloped, slender, and even infantile. Atrial septal defects represent the only congenital cardiac anomaly which is frequently associated with paroxysmal tachycardia and auricular fibrillation. Extrasystoles, atrial flutters, ventricular escape and atrioventricular disassociation have been recorded. Dexter lists some of the more common complications of atrial defects as: 1) cyanosis tardive or late cyanosis which appears with the reversal of the shunt when the pressure in the right atrium exceeds that in the left; 2) pulmonary vascular disease; 3) right ventricular failure; 4) left ventricular failure, which was noted in 14 of 60 cases; and 5) mitral stenosis which is rare.⁵

On physical examination inspection of the chest wall frequently reveals a bony promi-

nence and a bulging of the left side of the sternum in the adjacent rib cage. Palpation and percussion often reveal enlargement of the heart with the apex being displaced downward to the left with the right border to the right side of the sternum. The blood pressure is usually within normal range. There is frequently a widened pulse pressure and a bounding peripheral pulse. Extrasystoles are very common. Murmurs present in patients with interauricular septal defects vary to a significant degree. The pulmonic sound is often accentuated. There may be little or no murmur in infancy and early childhood but the majority of patients present a systolic murmur which is heard widely over the precordium and is most intense in the second or third interspace to the left of the sternum. It is thought to be due to the increased blood flow through the pulmonary valve orifice or a relative pulmonic stenosis. Friedberg reports that in about one third of the cases there is an apical diastolic murmur. This is not due to an associated mitral stenosis but probably to a functional or relative tricuspid stenosis caused by the large blood flow through the tricuspid orifice. In cases of ostium primum there are associated low pitched diastolic murmurs in the tricuspid region because of the very marked increase in blood flow through the functional tricuspid stenosis. With the development of congestive heart failure, cervical veins become very prominent and in the cases of atrial fibrillation there may be a systolic pulse in the liver and the cervical veins.

The typical findings on the chest roentgenogram and cardiac fluoroscopy are: 1) a prominent main pulmonary artery; 2) a small aortic knob or absence of the aortic prominence; 3) prominent hilar shadows and pulsation of the hilar vessels with increased pulmonary vascularity; 4) there is frequently a prominent right atrial shadow in the posterior anterior and oblique views; and 5) right ventricular enlargement. The left ventricle may also be enlarged in some cases.

Angiocardiography is sometimes used to delineate the type of heart disease present and with special techniques the actual passage of the contrast media through the septal defect may be demonstrated. By more conventional

angiocardiography, the presence of intra-atrial septal defects may be indicated by early opacification of the left atrium, by maintained opacification of the right heart or occasionally by actual visualization of the return of dye to the right heart.

The ECG usually shows right axis deviation. Incomplete or occasionally complete right bundle branch block is an almost constant finding. Auricular enlargement may be shown by a very large T wave and a widening and notching of the QRS complex. Friedberg states that incomplete right bundle branch block in a case of congenital heart disease should suggest the presence of an interatrial septal defect.

Cardiac catheterization is probably the most important ancillary procedure in the diagnosis of atrial septal defects. The diagnosis can be made with relative certainty and valuable prognostic information obtained regarding accurate measures of the flow through the septal aperture. When the catheter can be passed through the auricular septal defect, this offers positive proof of its existence. Samples of blood from the right auricle, right ventricle, and pulmonary artery generally show an oxyhemoglobin saturation of 80 to 90 per cent, which is greatly in excess of that found in the vena cava.

The selection of patients for surgical correction of the septal defects is dependent upon the degree of disability experienced by the patient. If there is significant disability due to exertional dyspnea or recurring episodes of heart failure, operation should be advised. By radiographic and electrocardiographic studies, there should be evidence of right ventricular hypertrophy in these candidates for operation. Catheterization studies should show pulmonary blood flows at least twice systemic blood flow. Some feel that with larger pulmonary blood flow, the operation is probably indicated in asymptomatic patients. The combination of pulmonary hypertension and a large left to right interatrial shunt are regarded as the main indications for operation.

The technique of atrio-septo-pxy has been described by Bailey and his co-workers as a satisfactory method of closure. After digital exploration of the septal defect by way of the

right atrial appendage, a progressive approximation of invaginated right atrial wall to the periphery of the septal defect is carried out by sutures placed through the wall of the enlarged auricle. This technique limits the repair to defects with complete rims in the middle of the septum. The repair of a large defect without a septal rim and in continuity with the bicuspid and tricuspid valves would result in obstruction of the vena cava or tricuspid valve. It would not be feasible to use this method in young children with appendages not large enough to admit the exploring finger.⁶ In 50 cases with atrial septal defects in whom closure of the defects were performed by atrio-pxy, there were 5 deaths in 37 patients with persistent ostium secundum and 8 deaths in 13 patients with persistent ostium primum. Clinical improvement was noted in the majority of the 29 patients followed up to 30 months after surgery. Post-operative catheterization in 24 patients indicated obliteration of the intercardiac shunts in 22.⁷

Another closed tactile method for closure of interauricular septal defects has been described by Björk and Crafford.⁸ This consists of passing a needle and suture through the right atrial wall, subendocardially in the rim of the defect, through the upper portion of the interventricular septum, and out through the posterior atrial wall. This suture is placed with the aid of the finger in the right atrial appendage and is made possible by a dissection in the groove between the right and left atrial walls. The suture is tied over a fibrin-foam sponge between the superior vena cava and the right pulmonary veins, thus closing the defect. This group has performed surgical closure of the atrial septal defects in 19 cases with 2 deaths.⁹

A third technique permitting closure of an interauricular septal defect has been described by Gross who used the "well" technique. Following an exploration of the right auricle through the appendage, a funnel shaped rubber well was sewn into place into the auricle and when the atrial clamp was removed, blood was allowed to flow up into the well. The low pressure present in the right auricle permitted digital exploration of the lumen of the auricle and working space to re-

pair the septal defect. The closure of the interauricular septal defect was accomplished by use of various plastic prostheses or polyvinyl sponge. According to some writers Gross has now discontinued use of this method in favor of atrioseptopexy. This type of operation is contraindicated in patients with pulmonary hypertension and an elevated right atrial pressure.^{10, 11}

Swan has demonstrated more recently the feasibility of open cardiac operation, and its application to repair of interauricular septal defects under direct vision. A relatively dry field is obtained by complete cardiac inflow occlusion with the patient in hypothermia with a rectal temperature of approximately 28° to 32° C. At this body temperature, a period up to 8 minutes is available for inflow cardiac occlusion and repair of the atrial septal defect by direct vision. This procedure has the advantage of direct observation of the defect and more accurate repair but is limited by the side effects of hypothermia. With the open-heart method one should be more certain of an accurate and complete repair and of finding and repairing associated anomalous veins and multiple defects. Swan reports a series of 42 patients operated upon for auricular septal defects with 7 deaths. Complete closure was felt to be obtained in 22 patients. Of 36 patients operated upon for a persistent ostium secundum, only 4 died.¹²

Direct vision repair of interauricular septal defects may also be performed using an extracorporeal pump oxygenator circuit as described by Lillehei and his group. The pump oxygenator is still in the process of development and further clinical trials but offers promise of replacing hypothermia as a means for direct repair of the atrial septal defects.

After reviewing the previously described methods for closure of interauricular septal defects, it was decided to investigate further the possibilities of direct vision repair under hypothermia. Large atrial septal defects were made in dogs under direct vision and closed either by a second cardiac inflow occlusion at the same operation or at an interval of one to two weeks. The dogs were placed in an ice water bath and the temperature lowered to approximately 31° C. The temperature usually con-

tinued to fall rapidly to the level of 26° to 28° C. after removal from the ice water bath and was stabilized throughout most of the operative procedure. The pulse rate of 140 to 180 usually fell to a range of 50 to 75 per minute with the lowered temperature. A right lateral thoracotomy incision was used. The inferior and superior vena cavae were dissected free and encircled with umbilical tape. A Harken auricular clamp was placed over the right atrium and stay sutures of 3-0 silk were placed at each end of the proposed incision. An incision was made in the atrium. The intracardiac procedure was then performed after cardiac inflow occlusion. A defect one-half to one centimeter in diameter was made in the atrial wall. The heart was then filled with saline by flooding the entire atrium and the clamp reapplied to the atrial wall. In many cases the heart was allowed to return to its normal beat by removal of the occluding clamps and after an interval of ten minutes, the procedure was repeated for closure of the interauricular defect. At the time of closure various methods of preventing the trapping of air in the left atrium were used. The insertion of a polyethylene catheter seemed to be effective as was the flooding of the atrial chamber just before the sutures, which were previously placed, were tied. After closure of the incision, the animals were then placed in a warm bath of approximately 42° C. and warmed to the preoperative temperature as measured by a rectal thermocouple. The surviving animals were sacrificed at a later date for observation of the healing stage of the septal defect repair.

As a preliminary procedure in order to perfect the surgical technique, 16 animals were operated on with inflow occlusion and under direct vision without hypothermia. Creation and closure of an auricular septal defect was performed. Of the 16 operated on under normothermic conditions, 7 died at operation and 2 died immediately postoperatively. This high mortality was expected although the duration of the inflow occlusion was purposely made very short.

A total of 30 operative procedures were performed on hypothermic animals with the previously mentioned operative technique. Of

these 30 cases there were 9 operative deaths. Ten additional animals died in the immediate post-operative period.

There were four cases of ventricular fibrillation in the hypothermic animals as opposed to only one case in the normothermic dogs. There was no significant difference in the occurrence of air embolus in the two series of studies. The high incidence of post-operative death in both series of cases but particularly in the hypothermic group, was unexplained.

The period of inflow occlusion in most cases ranged from 3 to 6 minutes. The occurrence of air emboli in the coronary vessels frequently preceded a fatal ventricular fibrillation but in 2 animals air embolus was noted and the air evacuated without an occurrence of a fatal fibrillation. None of the animals having ventricular fibrillation during hypothermia survived. When the surviving animals were sacrificed, the septal defect was closed and healed in every case.

RESULTS OF CREATION AND CLOSURE
OF ATRIAL SEPTAL DEFECTS IN
FORTY-SIX DOGS

NORMOTHERMIA

Total operations	16
Died at operation	7*
Died immediately post-operatively	2

Causes of Death

Ventricular fibrillation	1
Empyema	0
Air embolus	3
Acute dilatation	1
Technical errors	1
Unknown ^o	5

HYPOTHERMIA

Total Operations	30
Died at operation	9*
Died immediately post-operatively	10

Causes of Death

Ventricular fibrillation	4
Empyema	1
Air embolus	2
Acute dilatation	0
Technical errors	7
Unknown ^o	6

^o Since the head was not opened at autopsy, a large number of the unknowns may represent cerebral air embolus.
^o Some animals presented more than one cause of death. Autopsies did not include examination of the brain.

Discussion: The comparison of the normothermic and hypothermic procedures using identical operative technique reveals that less

than one third of the animals died during operation under hypothermia and almost one half under normothermia. This would appear to indicate that the hypothermia is effective in prolonging the period of cardiac occlusion which permits survival. The increased incidence of ventricular fibrillation in the hypothermic animal is consistent with all previous experimental and clinical experience. Ventricular fibrillation is probably the most common and the most fatal complication of hypothermic anesthesia and has been reported to occur more frequently in diseased hearts than in the normal. Ventricular fibrillation is seen as a result of excessive handling or trauma to the ventricle during hypothermia and also is reported frequently to occur following coronary air embolism.

Swan reports that recent experiences indicate a lower incidence of fibrillation with temperatures at a higher level (30 - 32° C.) One group of workers has demonstrated very effectively that injection of procaine into the sino-auricular node prior to the time of inflow occlusion markedly decreases the incidence of ventricular fibrillation and this technique has been used in clinical applications of this study.¹⁴ The tendency towards fibrillation in patients with respiratory acidosis has also been demonstrated and for this reason all of the animals used in the study were subjected to artificial hyperventilation throughout the course of hypothermia. Since this group of animals has been studied, the use of neostigmine by coronary perfusion has been shown to be highly protective against ventricular fibrillation in the cold canine heart.¹² Therefore, in patients subjected to hypothermic anesthesia for interauricular septal defects as well as for repair of other cardiac anomalies, neostigmine has been injected into the proximal occluded aorta to permit coronary perfusion.

The presence of air emboli in the coronary arteries in both groups of animals studied stresses for us the importance of measures to prevent this occurrence and a subsequent ventricular fibrillation. Cardiac outflow occlusion clamp has helped reduce the incidence of air embolus in the cases studied. In clinical cases a bilateral anterior thoracotomy incision has been used instead of the experimental

right thoracotomy incision in an effort to place the cardiac opening in the uppermost portion of the heart. Lateral or vertical tilting of the operative table is used to assure achievement of this objective. The flooding of the heart chambers with saline solution has helped to prevent the occurrence of air embolus in the coronaries. Massage of the air bubbles in the coronary vessels has reported to have been effective in preventing a fatal ventricular fibrillation.

The results of this series of experiments have made possible the use of hypothermia with cardiac inflow occlusion in a significant group of patients at this institution. This experimental technique in a modified form has been used clinically with satisfactory results. Although the use of hypothermia carries a definite risk, it is believed that at the present time it is a valuable adjunct in the repair of interauricular

septal defects and in selected extracardiac lesions.

Summary

The anatomical characteristics of interauricular septal defects are described.

The symptoms and signs of the lesion are reviewed, along with the findings on accessory examinations consisting of plain roentgenography, electro-cardiography, angio-cardiography and cardiac catheterization.

The features of the closed methods of repair are described.

Likewise the features of the open methods of repair with and without hypothermia and cardiopulmonary bypass are reviewed.

The technique and results of the applications of the hypothermic technique through the creation and closure of interauricular septal defects in dogs are described.

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THE PHYSICIAN IN CHILD ADOPTION

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The role of the physician in child adoption is important and indispensable. The physician's part cannot be delegated or done by others. On his skill and thoroughness may rest the fate or happiness or tragedy of another. The physician's examination cannot be undertaken lightly or perfunctorily. Successful child adoption, to a large measure, depends on a sound baby and healthy, well-adjusted parents, both natural and adoptive. The general practitioner, pediatrician and obstetrician are, naturally, most frequently involved in these examinations, but all branches of medicine may be called for advice and help. The medical aspect, then, reflects upon the entire profession.

Inescapably, the social, legal and medical aspects of child adoption overlap. Each participant in the adoption picture should confine his efforts, as much as possible, to his particular field and each make available to the others such information as may help. All of the findings are necessary for the complete adoption picture.

Even before the machinery of adoption is started, the physician may be of inestimable help in counseling with parents considering adoption, or with a mother about offering her child for adoption.

The wise and thoughtful physician may find the reasons for adoption to be a natural yearning and love for a child with all circumstances favorable so that he can encourage the undertaking, or, he may discover the reasons for adoption to be invalid—as an interest for a bored, discontented housewife, a security for an older childless couple desiring a child to care for them in old age, companionship for a neurotic wife afraid to be alone or a mistaken idea on the part of the wife that her drunken husband will be reformed. However, the physician may know the home life to be one of discord and immorality, or that there is a repeated criminal record. Thus the idea of adoption can be immediately discouraged.

The mother of a child born out of wedlock, who considers offering her baby for adoption, may counsel with the experienced physician and trained social worker.

When the decision is finally made to offer the baby for adoption, there is usually emotional upset or shock from the reality and finality of the separation. Psychological adjustment should, therefore, be started as soon as possible.

Again, while the parents are waiting indefinitely for a child, this period offers the occasion for training in infant or child care. Confidence and reassurance can be developed so the actual receiving and care of the child will be accomplished without unnecessary anxiety and uncertainty. The adoptive parents held in lengthy suspense month after month, not knowing when the adoption will go through, may develop nervous disorders and emotional suffering. These delays are, in part, due to current adoption practices, an overload of case workers, and a greater demand than the supply of babies.

Every child and parent concerned with adoption should have a thorough medical examination and opinion concerning physical and mental fitness.

A qualified physician should examine the child carefully for physical defects and for evidences of unfavorable traits that may subsequently develop. An examination at birth may rule out gross evidences of congenital defects, but may not immediately reveal blindness, deafness, affections of the brain, nerves, and muscles and some other conditions. A subsequent examination, perhaps at three months, may reveal defects not ascertainable at the examination immediately after birth.

It is, therefore, obvious that adoptions consummated shortly after birth carry more unpredictable physical risk than at a later time. It is further obvious that no physical examination can necessarily detect completely or prognosticate the baby's physical or mental

future. Licensed adoption agencies recognize these risks and advise withholding final adoption practices up to one year, although the baby may be placed with the adoptive parents during this time. It is important that the newborn baby be placed as soon as possible in the home of the adoptive parents rather than in a boarding home. The love and the care of the foster-mother cannot be duplicated by an institution, and the health and security of the child will be greatly helped.

It is tragic for adoptive parents to obtain a child with serious defects which could have been demonstrated before adoption, and which now make the child a chronic invalid without hope of normal existence.

The examination of the natural parents may reveal conditions that do not immediately show in the infant, but which could develop later, as examples, tuberculosis, manifestations of syphilis or epilepsy, nervous or emotional instability or mental abnormalities, diabetes, hemophilia, and a long list of other conditions which alert the physician. This information should not only be available to the adoption agency or party responsible for carrying out the adoption but also to the physician examining the child.

The adoptive parents must be physically healthy, nervously and emotionally sound, and have no contagious or infectious conditions that would be hazardous to the child.

Can you imagine how unfair it would be to the child for the adoptive mother to have advanced cancer, a blood dyscrasia, hemiplegia, or other incurable condition that would shortly end in her death?

During the examination adverse social conditions might become apparent, as alcoholism of either parent, a disorganized home, a quarrelsome nature or undesirable traits of character. These findings should be referred for complete social evaluation. And conversely, a social worker may gain medical information of vital importance that should be made available to the physician.

I hope it becomes apparent how important thorough medical examination of the three parties, i.e., child, natural, and adoptive parents can be or how long it might take to do the examinations, and that more than one phy-

sician is very likely to be involved.

The investigation is a team work and has to be coordinated for the complete picture and proper recommendations for suitability or unsuitability.

The physician's role in adoptions may, at times, embrace sociological or legal aspects.

Not infrequently physicians are called upon for aid in securing a baby. The family physician, the obstetrician, or pediatrician may be requested by interested parents to let them know when he learns of a "fine baby" for adoption.

Frequently, the request comes from a close friend or patient, or, on occasion, from a lawyer. The physician, in such circumstances, may learn of a baby offered for adoption and, by so helping, may receive everlasting gratitude from the parents, while, from other quarters, he may be criticized as a so-called "go between".

This adoption participation is not unusual and is rather widely practiced. The physician has, more or less, inherited or followed in the established footsteps of his predecessors in adoption procedures.

No doubt there are abuses of the practice and circumstances may rightly or wrongly put the physician in an unfavorable light.

I have talked with several physicians who have been drawn into adoption procedures because of their contacts, and I am convinced that the physicians are acting with the best motives.

Most physicians do not know the laws covering adoptions, and follow the conventional or prevailing practices of the hospital and the community, never realizing how much they are taking upon themselves.

Many of the physicians who are better informed about the intent and scope of the law take part in the adoption role because they sincerely believe the law and the agencies do not operate for smooth, efficient adoptions and, hence, by conventional practice and an effort to do humanitarian service, take part in the non-professional aspects of adoption procedures, the physician having assumed that the necessary legal steps and plans have been made, when actually, the arrangements may be of an impulsive, expedient type so that the

physician unwittingly is lending his help and sanction to a procedure in which the child may be unprotected.

In most instances, the physician knows either the natural or the adoptive mother or both, and may have delivered the baby or examined it and, hence, feels he is in a position to know and act for the best intent of all participating parties. Under these circumstances the adoption is most often happily carried out.

Unfortunately, the participating physician may not know either parent as well as he thinks, or the home environment may be different from his belief, so that his well intended word or opinion may be amiss.

If such circumstances as above had had thorough social investigation, the faults would be known and a misconceived or recommended adoption would not have taken place.

It is, therefore, apparent that to save some children from being legally adopted by unsuitable parents or into impossible homes, all adoptions should have prompt and proper social investigation before being approved.

The procedure should apply to all alike and every medical and social safeguard thrown around the child, because it is he who usually suffers. You may ask why this is not done. Your answer is as good or as unsatisfactory as mine. I believe the remedy will be by specifically well spelled out adoption laws and practices.

We all know the roadblocks to revised laws, especially adoption laws, because so many adoptions are successful that the others are overlooked.

I believe the first step is to supply all physicians with a full picture of the current variable loose adoption practices and the injustices that may fall upon the innocent child.

I feel confident that an educational or fact-supplying program will immediately startle the medical profession as a whole, and their cooperation and sentiment will be good. Even now, medical societies, both state and national, are showing definite interest in obtaining better adoption laws.

In my state, the Medical Association, at its last meeting, passed a resolution endorsing the state Adoptions Committee's efforts in obtain-

ing better adoption laws and practices, and the Committee on Maternal and Child Welfare are further making an effort to protect the adopted child.

Physicians are daily devoting their lives to relieve and prevent suffering and they will not condone practices that can lead to misery and suffering of a child or parent. It is hoped that the clarified adoption picture to the physician will next spread to the parents and friends who will demand legislative revision of the adoption practices.

The physician would welcome and follow a revised act that spelled out his role and relieved him of pressure forces in child adoption.

The average physician is not legal-minded or suspicious of the backdoor adoption schemes that the mother of the newborn baby is about to impose upon him.

The physician, by nature, wants to help—not frustrate. He is apt to accept an unusual, early separation of the baby from its mother as an odd attitude of the mother rather than an irregular adoption procedure in the making.

The birth certificates, again, may be carelessly filled in or misinformation supplied by the mother or other person filling in the data for the physician's signature. An assumed name of parents, in years to come, in addition to other injustices, may deprive the child of his rightful inheritance.

The hospital may be careless in the safeguards to protect babies from illegal adoption practices. Those persons who foster racket adoptions know which hospitals are easy and careless. The hospital must assume its responsibility and alert the physician and authorities when irregular adoptions appear in the making.

In conclusion, I wish to stress the following points:

1. Careful physical and background examination of baby, natural and adoptive parents.
2. That adoptions be carried out as thoroughly and quickly as possible for the good of the child and parents.
3. Revision in the adoption codes that spell out precise procedure and safeguards so that the role of the physician, hospital, social worker, and attorney will be definite and all aimed for the protection of the child.

4. An educational and fact-revealing campaign for the physician with anticipated grassroot extension to the parents and friends.
5. Cooperation and sharing of all information and findings that better adoption practices may result.
6. Regardless of laws, social studies and medi-

cal examinations, improvements in adoption practices will come about only when all concerned put the plight or best interest of the child first.

September 26, 1957

Read before the Southeastern Regional Conference, American Public Welfare Association.

THE PREFERRED SITE OF INTRAMUSCULAR INJECTION

REPORT OF A CASE OF PERIPHERAL NERVE PARALYSIS FOLLOWING INTRAMUSCULAR THERAPY.

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Introduction

The intramuscular injection of drugs and biologicals is a permanent part of medical therapy. In recent years, and especially with the advent of antibiotics, intramuscular therapy has increased considerably. It is not unusual for a post-operative patient to receive six to twelve injections of varied medications during a hospital day. Reports of complications following intramuscular therapy are somewhat less than common, particularly if one considers the large number of injections. However, when these complications occur, they are extremely serious and may cause total disability. Almost all intramuscular injections are given in the upper arm or upper outer quadrant of the buttocks. This duty is often entrusted to the inexperienced hand, and too often the injections are given with complete disregard for the underlying anatomic structures.

It is our desire to stress the advantage of the lateral thigh as the preferred site of intramuscular therapy and to condemn the buttocks and upper arms as sites of injection. We also hope to impress upon the medical and nursing professions the need for revision of a practice which is thought to endanger the patient's well-being and which may well invite undesirable legal action against the physician in charge. A case of sciatic nerve paralysis

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secondary to an injection of tetracycline hydrochloride is presented.

Case Report

A 53 year old colored female was admitted to Roper Hospital with lower and mid-abdominal cramps, nausea, and vomiting for twenty-four hours. The physical signs of intestinal obstruction with characteristic radiographic changes were present. A subtotal gastrectomy had been performed in 1943 for intractable duodenal ulcer. A vagotomy was done in 1945 for persistent pain. In 1954, she was admitted for acute intestinal obstruction secondary to a phytobezoar of the ileum. This was removed by ileotomy.

The history of multiple abdominal operations suggested adhesive obstruction. At operation a closed loop obstruction of the jejunum secondary to adhesions was found. The involved jejunum measured three feet and was gangrenous. This was resected and an end-to-end jejuno-jejunostomy was done. The post-operative course was not remarkable until the fifth post-operative day, when immediately following an intramuscular injection of tetracycline hydrochloride (100 mg.) into the left buttock, the patient complained of tingling and pain in the left foot. Shortly thereafter she noted numbness and weakness of the left foot and leg. Upon examination at this time there was no evidence of thrombophlebitis. The left foot and leg were warmer than the right but there was no swelling or tenderness. There was loss of pain and touch sensation over the lateral aspect of the lower part of the leg, and the dorsum of the foot. There was paralysis of the plantar flexors of the foot and weakness of the dorsiflexors of the toes and ankle. Weakness of the hamstrings was also present. Treatment consisted of physiotherapy, massage, and passive motion. A posterior plaster splint was employed to minimize foot drop. The patient was discharged

eleven days after the onset of her difficulty.

She was re-admitted to the hospital three days after discharge, complaining of pain and swelling of the left foot. The foot was tender to touch and there was a large bulla present over the dorsal and plantar surface. There was anesthesia over the lateral surface of the foot to the level of the lateral malleolus, with hyperesthesia over the medial portion of the foot. There was a progressive slough of skin over the dorsum of the foot. No return of sensory or motor function was evident. Treatment was limited to physiotherapy and local care of the wound. When seen in the out-patient department one month later, the rather marked foot drop remained with no change in the motor or sensory findings except for return of some touch sensation over the posterior aspect of the upper part of the leg.

Discussion

Turner¹⁵ in a letter to the editor of *Lancet* in 1920, was the first to decry the use of the upper arm and buttocks for the site of intramuscular therapy, and recommended a change to the lateral thigh. His advice is apropos now as then.

"The gluteal region appears to enjoy a traditional reputation for this purpose, but surely with less justification than as the time honored seat of castigation! The area is vascular, is abundantly bestowed with important nerves, and is subjected to the constant physiological traumatism involved in sitting and lying, to say nothing of the activity associated with walking.

I would like to suggest that the region of the outer side of the thigh, where lies the great vastus externus muscle, is as nearly as possible the ideal place for all types of intramuscular injections. Here we have a large mass of muscle protected by the strong fascia lata and embedded in so much cellular tissue as to allow ample room for distention. The area does not contain any important nerves or large blood vessels, and it can be readily freed from physiological traumatism as any other part."

In 1944, Turner¹⁶ reported several cases of secondary hemorrhage from the superior gluteal artery complicating an abscess secondary to the injection of quinine into the buttocks. Ligation of the main arterial trunk was required for hemostasis. He had observed many soldiers with severe neuritis and paralysis of the sciatic nerve following quinine injection. Intramuscular sulphapyridine was noted by Frankland⁶ in 1941 to cause peripheral nerve damage. Sulphapyridine was

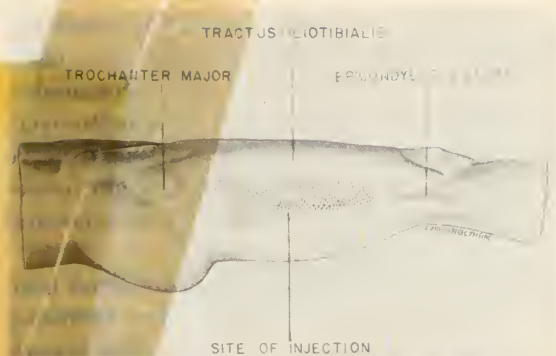


Diagram 1

Lateral view of the thigh in the recumbent position. The stippled area represents the area in which injection should be given.

also reported by Elkington⁴ to have caused sciatic and radial nerve damage in three cases and he advised that injections be given in the vastus externus. Similarly, in 1948, Krishna¹⁰ advised a change from the buttocks to the lateral thigh as the preferred site of intramuscular injection. He related that injections given subcutaneously were much more painful and less readily absorbed than those given in the muscle belly itself. He stated that the gluteus muscle often lies beneath a thick subcutaneous layer, that frequently injections did not reach the muscle, and therefore were painful. On the contrary, injections in the lateral thigh were readily placed in the muscle belly. It was noted that the upper outer quadrant of the buttock was richly supplied with cutaneous nerves and was a very painful site for injection. He felt that the gluteal region "should be declared the 'prohibited area' and 'out of bounds' to the intramuscular needle."

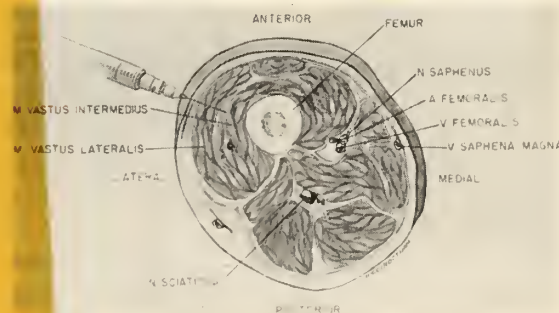


Diagram 2

Cross-section through the mid-thigh showing the large muscle mass available and lack of vital structures in the lateral portion.

Most of the case reports of complications following intramuscular therapy have been those of penicillin injections, but the sulfonamides, streptomycin^{14,11,3} and di-hydrostreptomycin have also reportedly caused peripheral nerve damage. Tarlov *et al* even found slight neurologic changes after experimental circumneural injection of saline or novocaine.

In 1946 Kolb and Gray⁹ first reported peripheral neuritis as a complication following penicillin injection. At that time other reports indicated a toxic effect of penicillin on the central nervous system. Johnson and Walker⁸ reported convulsions in a patient receiving intraventricular penicillin. A convulsive factor in penicillin was also described by Johnson and Kollros.^{17,18} Borkowski² in 1947 supported the work of Walker and his group and was able to produce convulsions and EEG changes in cats by applying penicillin-soaked pledgets to the cerebral cortex. Subsequently many reports of complications following intrathecal penicillin appeared.^{13,5,12}

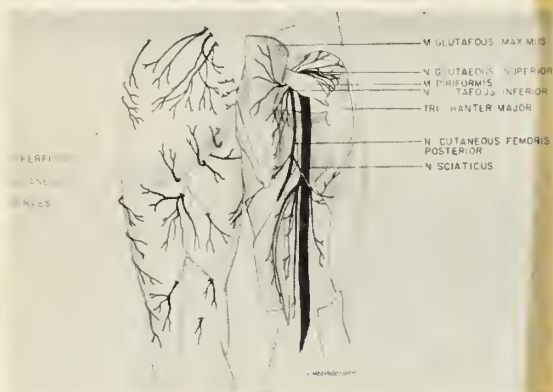


Diagram 3

The left buttock and thigh showing the superficial cutaneous nerves. Right buttock and thigh showing the gluteus maximus retracted medially and exposing the abundant nerves of this area.

Kolb and Gray in their report described seven cases in which patients receiving intramuscular injections of penicillin developed a localized peripheral neuritis. The neuritis in these cases was characterized by an onset of 10 to 21 days after the initial injection. The motor disability was greater than the sensory disability in each case. Recovery of function was rapid in all cases. They suggested that the cause was a delayed systemic toxic reaction to

penicillin, and felt that direct injury to the nerve was not likely. Tarlov *et al* in later work produced experimentally similar delayed peripheral neuritis, which they felt was due to progressive inflammatory and fibrotic changes of a local nature.

In 1949 Broadbent *et al* reported four cases of peripheral nerve injuries following penicillin injection. These cases, unlike those of Kolb and Gray, developed symptoms immediately following the administration of penicillin. In all cases there was noted an immediate onset of pain and tingling in the distribution of the nerve, and complete loss of motor function of the nerve. The sensory disability improved rapidly in most cases and was completely cleared anywhere from three hours to ten months later. The motor disability resolved much more slowly, and in one case there was no improvement in ten months. Two cases of radial palsy were explored and external neurolysis gave no improvement.

Holbrook and Pilcher,⁷ in 1950, reported a case of sudden pain and numbness in the left arm with wrist drop following an intramuscular injection of calcium penicillin (300,000 units) in peanut oil and beeswax. A month later there was noted to be complete radial paralysis. The radial nerve was explored and was found to be completely necrotic for approximately 10 cm. There was necrosis of the adjacent muscle also. This stimulated their study in which the sciatic nerve was exposed in dogs and intraneural and intramuscular injections, in proximity to nerve trunks, of penicillin and its combinations were given. They found that severe sciatic nerve injury resulted from injection of sodium penicillin and calcium penicillin into the nerve. Woodhall *et al*¹⁹ injected various salts of penicillin and streptomycin into the sciatic nerve of cats. They found an inherent toxic effect upon peripheral nerve axons that may result in axonal degeneration when antibiotics are injected within the nerve substance in high concentration. A more marked effect was produced by dihydrostreptomycin sulfate. Tarlov *et al* cite a case of almost complete sciatic paralysis following an intragluteal injection of penicillin. Two years later a neurologic deficit was still noticeable. This prompted a study in which the

sciatic nerve of rabbits was used. Various preparations, including streptomycin, dihydrostreptomycin, and aqueous procaine penicillin G, were injected around the nerve and into the epineural sheath or directly into the parenchyma of the nerve. The neuritis which followed was attributed to direct injection of material into the parenchyma of the nerve. Injection around the nerve or into the epineural sheath did not produce the intense and persistent neuritis. The nerve sheaths appeared to resist strongly the inflammatory reaction. In some cases, they found a late interval of 8 to 17 days before severe impairment occurred. This was similar to Kolb's cases as previously cited. They felt that operative therapy would probably be of no avail because there was an intraneural lesion and not extraneural compression. Matson on the other hand recommended early neurolysis in the treatment of peripheral nerve injuries due to faulty injection. He cited two patients with sciatic nerve paralysis. One had neurolysis after twelve months of conservative therapy without return of function. Two months later the first return of function was noted. The second patient who had received an injection of streptomycin had neurolysis within three weeks of onset of symptoms and improved within the first few weeks following operation and progressively for the next thirteen months with complete return of function. He recommended neurolysis if there was no progressive improvement within two to three weeks.

Augustine *et al*¹ in 1952 repeated the plea for the use of the lateral aspect of the thigh as the site for intramuscular injections and cited three cases of sciatic palsy following gluteal injections. They recommended that the injections be made along a line extending from the greater trochanter to the lateral femoral condyle below. They cited the following advantages. The injection can be given with the patient in either the sitting or the recumbent position; whereas with gluteal injections the patient must be turned. If the femur is struck, pain or injury is negligible. Incision and drainage in cases of infections is easily done because of the lack of vital structures.

Conclusion

The buttocks and upper arms have continued to be the usual sites of intramuscular therapy, without regard to the highly unfavorable consequences of their use. Peripheral nerve injuries when they occur after intramuscular injections may be irreversible and totally disabling. Peripheral neuropathy when it occurs is due not only to the toxic effect of the drug on the nerve tissue, but to resulting inflammatory changes. Paralysis may be immediate or delayed, and may cause irreversible nerve damage. External neurolysis is recommended if progressive improvement does not occur within approximately three weeks.

The lateral thigh is easily accessible in either the erect or recumbent position. Patients do not have to be turned. There are no vital structures in this area. There is ample muscle mass to accommodate repeated injections of large amounts. The muscle belly is easily reached beneath the tensor fasciae latae. Abscesses are easily drained without danger of damage to vital structures. Pain fibers are not as abundant. The area is not subjected to the constant trauma of sitting and lying. Inexperienced personnel can use this area without danger. (See diagrams 1-3.)

Despite repeated pleas for abandonment of the upper arm and buttocks and the use of the lateral aspect of the thigh as the preferred site of intramuscular injection, there has been no evidence of acceptance. It is hoped that the members of the nursing and medical profession will realize the potentially dire medical and legal consequences of the continued use of these areas, and will administer intramuscular injections only into the lateral aspect of the thigh.

Summary

The gluteal area and upper arms are unsatisfactory as sites of intramuscular therapy because of the possibility of secondary peripheral neuropathy or neuritis and its consequences. The site of injection should be changed to a less vulnerable area, such as the lateral thigh. A case report is included.

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SOUTH CAROLINA'S MATERNAL MORTALITY FOR 1955

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AND THE

MATERNAL AND CHILD HEALTH DIVISION; STATE BOARD OF HEALTH*

In a publication this year by the Committee on Maternal and Child Care of The American Medical Association, it was noted that there had been a 77 per cent reduction in the maternal mortality rate in the United States from 1945 to 1955. Dramatic improvement in the maternal mortality rate in several states and communities where continuous programs for thorough study of maternal deaths were in progress were also found. On the other side of the ledger, however, the studies revealed that 50 to 90 per cent of the maternal deaths had preventable factors. This, of course, is the whole purpose of a study of this type; that is, to uncover these factors and then take the necessary steps to avoid recurrence.

This is accomplished through the Maternal

Health Committee. The members of this committee are appointed by the South Carolina Medical Association from physicians in the specialty of obstetrics and members of the Academy of General Practice. The Committee Chairman prorates the death records among the various members for detailed study. Each case is then reviewed by the entire committee to determine actual cause of death, classification, preventability, etc. and the physician signing the death certificate is informed of the final decision. By this and other time consuming methods the way to continued reduction in maternal mortality is opened.

At a recent meeting we were told that South Carolina was "sick". By this it was meant that the maternal death statistics for South Carolina were somewhat high as compared with those of some of our neighboring states and with

*Presented at the Annual Meeting, South Carolina Obstetrical and Gynecological Society, Columbia, S. C., November 3, 1957.

the national averages. We do not have our tabulations for 1956 but we do have them for 1955 and after complete evaluation we find that perhaps we are not as bad off as one may think on superficial perusal of the final figures.

Table I

	Deliveries	Deaths	Incidence
White	38,875	5	1 in 6,975
Colored	28,166	61	1 in 454
Total	63,041	66	1 in 941
National Av.			1 in 2,631

Table I divides the total deliveries in South Carolina for 1955 between the white and colored races. In the white race there were 34,875 deliveries and only 5 deaths giving an incidence of one death for every 6,975 deliveries. This compares very favorably with the national incidence of one per 2,631 deliveries. The colored maternal death rate of one in 454 deliveries and the combined rate of one in 941 compares very unfavorably with the national average. The most striking fact which these figures show us is the marked discrepancy in the maternal deaths of the white and colored races. There is no need to dwell on the reasons for this discrepancy, but it does reflect very decidedly the value of good prepartal and obstetrical care.

Of the total 66 cases, the Maternal Health Committee was able to obtain the necessary details for complete evaluation on 56. Included are all those cases which are covered by the definition as given by the American Medical Association; that is, any woman dying of any cause whatsoever while pregnant or within 90 days of the termination of the pregnancy, irrespective of the duration of the pregnancy at the time of the termination or the method by which it was terminated.

Of the 56 cases, 41 were legitimate pregnancies and 15 illegitimate. The age varied from 17 to 44 years with an average of 30 years. The parity varied from 1 to 14 with an average parity of 4. There were 5 deaths occurring in the primagravida group. Fourteen of the deaths occurred in the home and 42 in the hospital. A number of the hospital deaths were terminal admissions, but none the less, were included as hospital deaths.

Forty-one cases were attended by a physician at the time of delivery and in 5 instances the physician was an obstetrician. There were

7 patients attended by a midwife and 2 unattended. At the time of death a physician was present for 52, the physician being an obstetrician in 7. One death was attended by a midwife and 2 were unattended. Fifteen deliveries were of living viable infants.

In judging the adequacy of the prepartal care, 12 were considered to have had adequate care, 28 inadequate and 12 none. The prepartal care was evaluated according to the circumstances of each individual case, and not by a set standard of a certain number of visits, etc. If a person was seen initially late in pregnancy by a private physician or in a clinic and subsequently received excellent care, this, nevertheless was considered as inadequate. Likewise, if a person was seen regularly by a physician or in a clinic but not cared for or managed in the manner considered optimum by the Committee, this also was judged as inadequate. It goes without saying that the judges were not present when the cases were under treatment and had they been, their decisions might have been altered. Allowing for all considerations, this still stands as a very weak point in South Carolina's maternity care and concentrated effort will have to be aimed at reducing this figure. Certainly in a number of instances the fault is with either the patient or the family or both, and not with the facilities available. Only through persistence will we be able to educate and help this kind of patient.

The delivery was a spontaneous vaginal delivery in 33 patients. The others delivered were by version and extraction in one, low forceps in three, assisted breech in two, and four were delivered postmortem. There was only one death following cesarean section and this occurred in a patient who developed lower nephron nephrosis following delivery for abruptio-placentae.

Table II

Hemorrhage—Primary or Contributing Factor	
1. Rupture of uterus	10
(a) Pitocin	5
(b) Version & extraction	1
2. Postpartum atony	12
3. Placenta previa	2
4. Abruptio placentae	5
5. Ectopic pregnancy	2
6. Rupture of liver	1

The maternal deaths in which hemorrhage

played a primary or contributory role are recorded in table II. In 10 cases the hemorrhage was secondary to ruptured uteri. Five of these patients had received pitocin prior to delivery. It was not determined by which route and in what doses the pitocin was used; in other words, pitocin could not be definitely incriminated in any given case, but it does seem more than a coincidence that 50 per cent of the patients with ruptured uteri had received this drug. The most frequent cause of hemorrhage is listed as postpartum atony. In several cases this was the best clinical diagnosis and if a more complete examination or autopsy could have been done, this diagnosis might have proven to be incorrect. Exsanguinating hemorrhage from a ruptured liver occurred as the terminal event in one patient with severe pre-eclampsia.

Table III

Toxemia—Primary or Contributing Factor	
1. Eclampsia	14
2. Severe pre-eclampsia	4
3. Hypertensive cardio-vascular disease	1
4. Hypertensive cardio-vascular disease with pre-eclampsia	7

Toxemia continues to play its prominent role as a causative factor in maternal deaths. As previously discussed, prepartal care for the indigent patient will have to be improved if we expect to reduce this figure. In other localities this condition is the cause of maternal deaths much less frequently and even though they may not have the volume or type of indigent patients we have in South Carolina, we must not use this factor as an excuse for our inadequacy.

Certainly everyone realizes the value of consultation, and in 24 cases or 42.8 per cent a second physician was called. In too many instances, particularly in the rural communities, the lack of consultation was due to the lack of availability. We have little to say for or against our autopsy rate of 27.7 per cent for it is approximately what one would expect. Again we must not let the circumstances excuse us.

The primary causes of death are recorded in Table IV. Hemorrhage due to causes previously mentioned accounted for 25 of the 56 cases or 44.6 per cent, and in almost all cases the hemorrhage was considered as preventable. Further discussion of this will come later.

Table IV
Primary Cause of Death

	No.	S. C. Per- cent	Missouri 1955	N. C. 1954	Charity Hosp. 1946- 1955
1. Hemorrhage	25	44.6	53.7	22.9	16.1
2. Toxemia	17	30.4	17.9	27.7	27.6
3. Infection	3	5.3	2.5	4.7	22.3
4. Embolism	9	16.1	2.5	11.4	10.7
5. Lower nephron nephrosis	1	1.8			5.3
6. Pulmonary edema	1	1.8			
7. Anesthesia	0			6.0	1.4
8. Cardiac disease	0			1.3	

Comparing with Charity Hospital's death rate due to hemorrhage, which represents more the ideal situation, we find only a 16.1 per cent incidence. To account for this a number of factors are involved aside from the fact that blood is readily available; namely, physician attendance, recognition of pathological conditions early, condition of patients prior to delivery, etc. This, of course, points to the value of hospital delivery which is already generally appreciated and accepted. South Carolina's tabulations for the other causes of death, for the most part, are in the same range as other localities with the exception of anesthesia. It is interesting to note there were no obstetrical deaths due to anesthesia in 1955. This may be taken either as a tribute to the good obstetrical anesthesia used in South Carolina or it may reflect the fact that we don't use much of it.

Table V
Obstetrical Deaths

1. Preventable	42 (75 per cent)
(a) Management	19
(b) Technique	1
(c) Patient or family	16
(d) Midwife	6
2. Non-preventable	14

Forty-two of the deaths were judged to be preventable or, preferably, to have had avoidable factors. This represents 75 per cent of the total cases and falls in the range as found in the national study of 50 to 90 per cent having avoidable factors. Three assumptions were made in this evaluation; namely, (1) the physician possessed all the knowledge currently available related to the factors involved in the death (2) by experience he had reached a high level of technical ability and (3) he had available to him all the facilities present in a well organized and properly equipped hos-

pital. In a number of our cases these assumptions are not facts, but we are shooting for the absolute minimum of maternal deaths so we must assume that the ideal is possible.

It is planned that these statistics be tabulated each year so that we may be acutely aware of the difficulties and problems which are encountered with the increasing South

Carolina population. Through uniform classification of obstetrical deaths, we will be able to define our problems more accurately and by utilizing the proper educational channels, both within the profession and with the public, the avoidable factors in maternal deaths can be eliminated.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

MULTIPLE MYOCARDIAL INFARCTION

DALE GROOM, M. D.
Department of Medicine

Case Record—A 55 year old building contractor of robust physique was awakened during the night by a pain in the mid-chest. He described the pain as being of rapidly mounting severity, becoming excruciating, radiating over the entire anterior chest and down both arms, and accompanied by a profuse cold sweat. It was unlike any pain he had experienced before, although he did recall that on several occasions during the previous few months he had noted a mild discomfort in the chest during strenuous physical exertion but this had not prompted him to seek medical attention.

The clinical and laboratory findings on admission to the hospital were indicative of extensive infarction of the myocardium with impending congestive failure. Fever, tachycardia, and a diastolic gallop rhythm audible at the cardiac apex persisted throughout his illness. The patient remained profoundly weak, becoming dyspneic with advancing pulmonary congestion in spite of adequate oxygen, digitalis, diuretic, and anticoagulant therapy. He died suddenly on the seventh hospital day shortly after the exertion of using a bedside commode.

Autopsy examination revealed acute infarction involving both the anterior and posterior walls of the heart and the interventricular septum. Microscopic study of sections taken from these areas indicated the necrosis to be of several day duration.

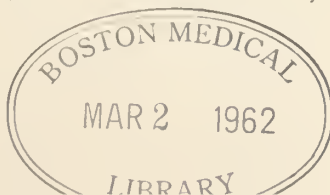
Electrocardiogram—The tracing illustrated here, made on the fourth hospital day, shows a regular sinus rhythm at the rate of 120. The P-R interval is at the upper limit of normal, measuring 0.20 sec. Amplitude

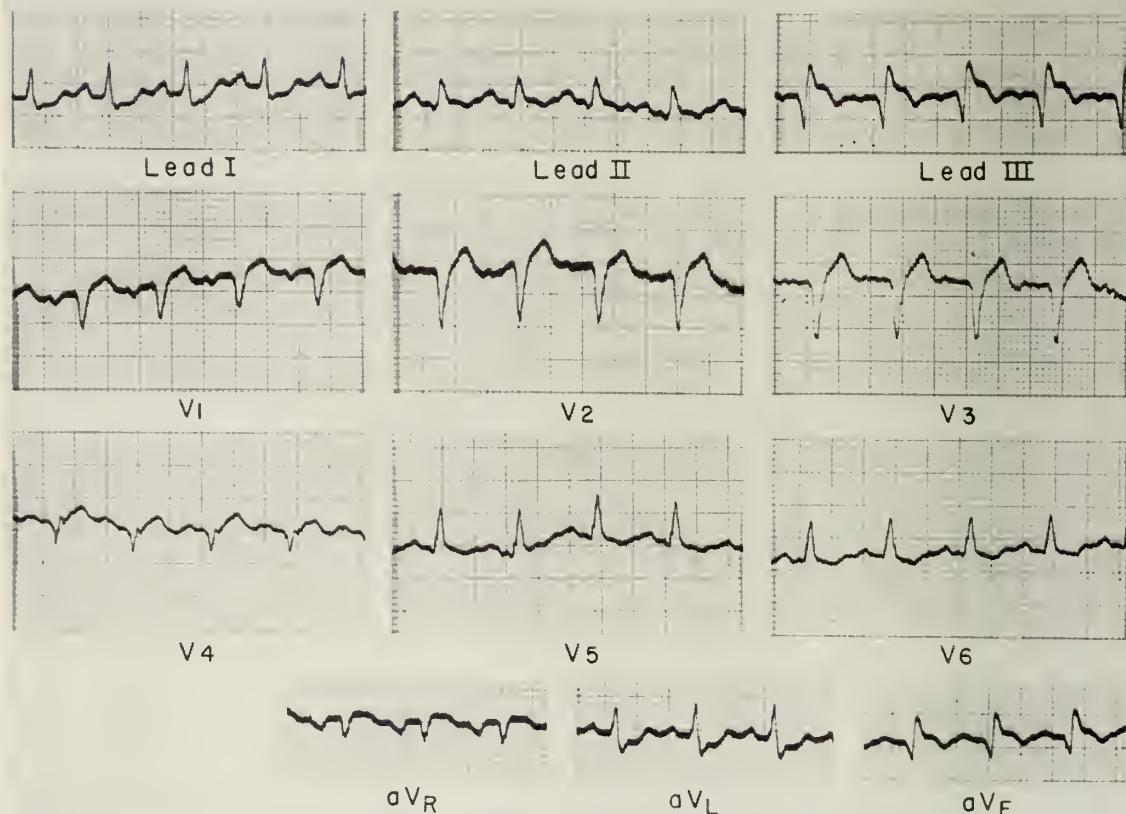
of the QRS deflections is somewhat low in all leads. Deep wide Q waves with elevation of the S-T segments and sharp inversion of T waves are evident in leads III and aVf and, to a lesser extent, in lead II. Reciprocal depression of S-T segments is seen in I and aVl. No R waves are present in the precordial leads from V-1 through V-4.

Discussion—The classical electrocardiographic signs of both anterior and posterior infarction are displayed in this tracing. Leads taken from the extremities reveal involvement of the posterior wall (actually the inferior or diaphragmatic area of the heart) as shown by the prominent Q waves in III and in aVf which faces the diaphragmatic surface. The elevation of S-T segments in these leads with the reciprocal S-T depression in leads from above signifies that the process is acute.

Additional damage is disclosed in the precordial leads which show that a large area of the anterior wall of the heart, which they confront, has lost its electrical activity as evidenced by the absence of R waves as far to the left as V-4. Presumably this means that the anterior wall is also infarcted. The fact that there is no indication of depolarization of muscle tissue in this area—no upward deflections—suggests that the infarction is probably a transmural one involving the entire thickness of the wall and also perhaps including the interventricular septum which immediately underlies this area. Injury to the septum and its conduction pathway had in fact been suspected previously because of an electrocardiogram taken on admission which showed right bundle branch block in addition to multiple infarction. Absent here are the tiny Q waves of septal activation which are normally seen in V-6.

The effects of multiple infarction on the electrocardiogram are of considerably more than academic interest. Depending largely upon the relative size and location of the infarcts, and their time relationship, several results may occur. In the case of an old in-





faction, abnormalities remaining in the complexes may serve to obscure the changes of a subsequent one, especially an extension of the damaged area. An abrupt change in T waves or the appearance of a current of injury may afford the only clue in the tracings of further injury. Or the electrocardiogram may actually become more normal in appearance following a second infarction. This is attributed to a "balancing out" of abnormal forces as in the case of inverted T waves or displaced S-T segments being reversed by the addition of other abnormal forces of opposite polarity and direction. Perhaps this explains in part why an occasional case of massive myocardial infarction shows a nearly normal ECG—this and the fact that there may be insufficient viable muscle remaining to produce the characteristic abnormalities. As a general rule, however, any appreciable destruction of muscle tissue will produce permanent changes in the QRS complexes of leads confronting that area, and these changes do not prevent the appearance of similar QRS abnormalities in other leads resulting from damage to the opposite wall of the heart.

In the case of this patient both antero-septal and posterior wall infarctions doubtless occurred at about the same time or at least within a matter of a few

hours. This is borne out by the lack of a previous history of infarction, by the fact that all four tracings taken during his illness showed evidences of involvement of both walls and the septum, and by the autopsy findings. When both opposite walls of the heart are damaged simultaneously the resulting currents of injury can be expected to in some measure cancel out, even to the point of concealing the acute nature of the process. Here however the S-T displacements produced by the injury to the posterior wall predominate, and if the precordial leads had been omitted there would have been no indication of any other involvement. Even with the V leads it is impossible to determine by this electrocardiogram whether the anterior infarction is an old one or acute, a point which can often be clarified by serial tracings.

The occlusion of more than one coronary vessel at the same time is almost certainly more than coincidence. One of the complications of acute infarction is further infarction of the myocardium. The fall in blood pressure which accompanies thrombosis of a coronary artery is undoubtedly conducive to thrombosis in other arteries, as is, perhaps, some degree of collateral spasm in the coronary arterial tree. Con-

ceivably an alteration in the blood clotting mechanism in response to the physical stress might also be im-

plicated, an aspect which has received relatively little investigation.

LYMPHATIC LEUKEMIA

TABULATIONS ON 2910 CASES TREATED WITH CHEMICALS

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Chemotherapy offers increasing hope to the leukemic patient today. The results of the management of all types of leukemia through chemotherapy are appearing so rapidly from medical centers throughout the world that it is impossible to keep abreast of the advances. A check by the author on the hundreds of clinical reports published since 1949 on just lymphatic leukemia shows that 2910 cases have received treatment with chemical agents. Actually the number of patients undergoing chemotherapy is considerably in excess of this total, for 49 of the publications covered in this tabulation gave no figures on the numbers undergoing treatment. A few observations on the 2910 cases, however, will give some appreciation of the scope and progress in this battle of the century.

Radiophosphorus. P^{32} leads in the number of cases treated with 665. More than 90% of these patients had chronic lymphatic leukemia. A remission rate of 35% is not high, but a dozen of the published reports fail to state the number of remissions observed. The types of remissions ranged from mere subjective improvement to complete clinical and hematologic remissions lasting months and even years.

Nitrogen Mustards. N-mustards were effective in 50% of the 505 patients tabulated, but a dozen of the reports again gave no data on the number of improvements noted. All but 13 of the cases were of the chronic type.

Triethylene Melamine. TEM induced remissions in 64% of 469 patients, with 13 reports giving no data on remissions. Only 35 of these cases were of the acute type.

ACTH and Cortisone. These two hormones, Furman University

with some of the newer derivatives like prednisone and fluorohydrocortisone, accounted for 60% of the remissions recorded in 417 cases, with a dozen publications failing to report any figures on remissions. For the first time in this tabulation, the number of patients with acute leukemia surpass the number with the chronic form of the disease.

Folic Acid Antagonists. Remissions in 366 patients on folic acid antagonists averaged 51%, with 4 reports indicating no numbers on remissions. Only 25 of the patients had chronic lymphatic leukemia.

6-Mercaptopurine. 6-MP had a remission rate of 64%, tying that observed with TEM, with only 2 reports failing to give the number of remissions. All except 6 of the 127 cases had the chronic form.

Urethan. This chemical accounted for 63% of the remissions recorded in 121 cases, with 4 articles failing to indicate the number improved. And only 11 of the cases were acute leukemia.

Miscellaneous Agents. More than a score of chemicals have been administered to 240 acute and chronic lymphatic leukemia patients. In spite of a dozen reports furnishing no data on remissions, a remission rate of 70% has been tabulated. This showing indicates that a number of these chemicals should be given a more extensive trial.

Judging from the above data, one may look with confidence for one of the types of leukemia to yield eventually to a more satisfactory chemical management of these blood diseases.¹

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PRESIDENT'S PAGE

Death on the highways of South Carolina took over 700 lives in 1957. An estimate of injuries and misery as a result of accidents cannot be made, but it must be many times the loss of life.

Competent authorities now know that a large proportion of these accidents have resulted from the physical and mental inadequacy of the drivers. The highway department, as well as the governor, has for several years recommended to the Legislature that some type of medical examination program be authorized by law.

The State Highway Department has now requested the State Medical Association to appoint a committee to assist in setting up minimum mental and physical requirements which a driver should meet. The Highway Department wishes requirements for the initial examination as well as requirements for drivers who already have their licenses.

The Industrial Medical Association feels that the first and most important step must be taken by the practicing physician.

You will be glad to know that our Association is forming a committee to work with the State Highway Department on safety.

Certainly your life and mine should not continue to be endangered by the physically or mentally inadequate driver.

D. Lesesne Smith, M. D.

Editorials

THE HOLE IN THE ANTIBIOTIC BLANKET

Because the prophylaxis of a certain few diseases appears to be achieved by the use of antibiotics, the unwarranted assumption has been made that the generous use of these agents prevents a multitude of other infections. Practitioners in all fields like to "cover" their enterprises with large or prolonged doses of antimicrobials and go rather smugly about their business in the assurance that all will be well.

Prophylactic value has been actually demonstrated to be effective only against a few etiologic agents, such as the beta-hemolytic streptococcus, the meningococcus, the gonococcus, and certain shigella species. The list of failures with other organisms is long.

A study of recent date puts a damper on the still prevalent comfortable thought that most infections can be prevented by premedication. A group of comatose patients were treated with "prophylactic" antibiotics. The mortality rate was not influenced, and more pulmonary and cutaneous infections developed than in the control group. Strains of micrococci isolated from the treated group were more resistant to antibiotics than were those cultured from the controls. Bladder infection from indwelling catheters was not prevented. The conclusion is, that in comatose patients at least, "prophylaxis" is futile.

An editorial comment in the journal in which the report appears is very much to the point:

"It is disturbing as well as discouraging that so many physicians and surgeons continue to employ antibiotics and other antibacterial drugs almost routinely for prophylaxis in any and all situations in spite of the repeated demonstration of their failure to prevent infections. There is an increasing body of evidence that such wanton use of antibiotics may actually encourage implantation of organisms ordinarily uncommon in the respiratory or urinary tract except as transients or as saprophytes. Infections with such organisms are increasing in frequency and severity wherever antimicrobial agents are used in this manner, and these agents are therefore losing

much of their value in the treatment of the infectious complications of surgical and medical diseases as they occur in hospitals.

"The alternative policy of careful observation of the patient and vigorous treatment of intercurrent infections as soon as they are recognized, with antibacterial agents specifically directed against their causative agents, appears to be the only reasonable course to pursue and will probably yield the best results in the long run."

New Eng. J. Med. 257: 1001 (Nov. 21, 1957) and 257: 1048 (Nov. 21, 1957)

THE UNIVERSITY HOSPITAL

Despite the considerable unrest in academic medical circles about such issues as reorganization of the curriculum, the place of the professional medical teacher, the length of postgraduate training and its expense, the best choice of teaching methods, etc., to a large degree, clinical medicine remains best taught by some form of bedside precept system. Accordingly, a university hospital always must struggle to improve the care of its patients and to polish the services it renders. This is necessary not only to survive in what is becoming an increasingly competitive field, but also because the very highest grade of patient care and the best possible medical organization must always be sought by such a hospital if it is to discharge its duty to its students and house staff properly. The better the service, the better the training. This, of course, is another example of the accuracy of the aphorism, "Action speaks louder than words".

However, recognition of excellent medical care soon penetrates to the surrounding community, which will then demand its share of such services. If the professional staff of a hospital rendering these services yields to these pressures, giving more time to private patient care, the training programs must suffer. Therefore, an institution committed to training medical personnel remains constantly torn between these internal and external pressures. The only solution to these issues if proper teaching is to be maintained or improved, is

to increase the teaching personnel as service to the community is increased. Consequently, a period of fairly rapid growth should be expected of any institution with extensive teaching commitments provided the adjacent community needs and can absorb the services it offers as a necessary highly desirable by-product of its teaching. The increasing awareness of the lay public of advances in medical science, of the very large role played by all hospitals in medical care today, and of the growing importance of medicine as a science in patient care are all emphasizing the position of the large hospital. These facts are part of the explanation behind the increasingly important part teaching hospitals are playing in most areas.

Cheves Smythe, M. D.

POPULAR MISCONCEPTIONS ABOUT IMMUNIZATIONS

Since active artificial immunity is still partially an intricate maze to research workers, it is not surprising that one encounters many patients who do not fully understand its known principles.

In the first place, too many "healthy" people do not realize the value of immunizations, particularly in the absence of an epidemic. The community protection achieved by sufficient reduction of the percentage of susceptibles is known by too few.

Secondly, many parents are unconvinced of the merit of immunization in infancy. Procedures, selected for convenience, which include a check on immunization status on entrance to school have tended to magnify the matter of increasing the resistance of the school child to the detriment of the infant and preschool child, who are at greater risk.

Some do not know what immunizing agents are available while others request shots to prevent diseases for which there is no suitable antigen, such as malaria. Many are not aware of the importance of keeping a record of immunizations received. There is important confusion between tetanus toxoid and tetanus antitoxin. Allied to the belief that the injected antigen is protective in itself are the concepts that protection is either immediate or total or both. These false ideas can undermine public

acceptance when a disease develops in a person specifically "immunized" against it. Thinking that protection is immediate fosters delay in securing immunization until an epidemic is at hand.

The belief that active artificial immunity is permanent has some basis in older scientific thought which was later proved incorrect. (This statement does not apply to Salk vaccine as the duration of its protective effects has not yet been determined.)

Misconceptions of the severity of reactions to immunizations are a deterrent to some. Perhaps they had a grandfather who "almost lost an arm" from smallpox vaccination many years ago. They do not realize that improved techniques of antigen purification and administration with better supportive measures have dramatically reduced the incidence and sequelae of untoward reactions.

The prevalence of varying degrees of misunderstanding is one of many signs that medical practice can never be reduced to routine mass techniques. There is more to achieving an optimum immune status for our patients than merely inserting a hypodermic needle in the tissues.

Leon Banov, M. D.

THE NEED FOR NURSES

With the rapid advances in medicine and surgery, it is difficult for all branches of medicine to maintain an equal pace. The nursing profession has made a vigorous effort and with considerable success in keeping pace with these rapid advances.

The National League for Nursing has this year set 300 trained nurses per 100,000 population as the future need for ideal nursing care. It is not anticipated that this goal can be reached prior to 1970. At the present time, there are 430,000 professional nurses or 258 nurses for each 100,000 population. The anticipated increase in population, both the natural increase and the percentage of older people and greater medical insurance coverage, and an increase in the medical services rendered to the public, will require more trained nurses.

A questionnaire sent to thirteen Nursing School superintendents in South Carolina in-

icated that certain common problems are facing nursing educators. Probably the most common and most immediate need is more teachers. There also appears to be a general deficiency of nurses which ranges from not less than ten percent and in some institutions approaches twenty-five percent. This lack of nurses is likely to be enlarged with the present building progress of our hospitals.

Some of the nursing graduates are attracted out of the state for various reasons, usually higher pay. The answers to the questionnaires showed forty to sixty-five percent of graduates of South Carolina schools seek employment elsewhere than in their alma mater. The basic salaries for nurses ranged from \$180 to \$235. There was a unanimous opinion that salaries were inadequate to continue to attract good personnel.

Most superintendents of nursing indicated that practical nurses may have to play a larger part in patient care. There were differences of opinion regarding establishing practical nursing schools. Every correspondent felt there would have to be an increase in nurses to staff the enlarging hospitals.

To fill this need there must be larger and possibly more nursing schools. The South Carolina nursing schools have worked diligently to staff our hospitals and other health services adequately. However, there are increasing pleas from all sides for more nurses in all types of nursing care. The administrators of hospitals find themselves being criticized for inadequate nursing services, both by the physicians and by the patients and their families.

Our leaders in nursing recognize that a certain percentage of nurses will be lost each year through the normal channels of marriage, quitting, and poor health. This overall year by year loss is estimated at approximately one-third of each nursing class. This loss is a national loss and does not reflect upon our nursing schools in this state. Of the remaining two-thirds of nurses graduating, by far the majority accept positions in their local hospitals or other nursing services. The question arises of how to best utilize the remaining nurses who do graduate from our state schools.

More use of practical nurses to relieve the clinical nurses for specific jobs, a greater con-

sciousness by physicians of the nurses problem, continued efforts by all interested parties to recruit more students in nursing, more flexibility in nursing curriculum, subsidy of students in nursing by hospitals which have no nursing schools, particularly the Veterans Administration and military forces should provide thought for further studies of this problem.

C. B. Hanna, M. D.

MR. HIGLEY VS. THE MEDICAL PROFESSION

Veterans' Administrator Harvey Higley, addressing the American Legion convention in September, declared that "a mere decade ago" few would challenge VA care for veterans with non-service-connected disabilities, if they were unable to pay for care and the VA had beds available. "During the past three years", he said, "certain individuals and responsible organizations have opposed hospital benefits for the non-service-connected."

"Some medical men, who usually are keenly aware of the need for proper public relations," said Mr. Higley, "now apparently believe that the public no longer is greatly concerned with the veteran and his problems. And so they no longer hesitate to attack medical care for veterans, with particular reference to those having non-service-connected disabilities."

Actually, the medical profession believes that the public has never been sufficiently informed concerning the veteran and his problems. As stated in the Council on Medical Service pamphlet, *The Trojan Horse* "the facts and philosophy behind the VA program have never been brought clearly to the attention of the American people."

Far from launching an undercover attack on veterans' medical care during a period of public apathy, the House of Delegates of the AMA specifically stated, in 1953, that "Every effort should be made to inform the profession and the public concerning the nature of the problem, the position of the American Medical Association and the reasons on which that position is predicated."

Secondly, the medical profession does not attack and has not attacked "medical care for veterans" generally; it has always upheld the provision of care at federal expense for service-connected conditions. Its opposition has been directed solely at federal financing of care for non-service-connected conditions and the presumption of service-connection without adequate grounds.

Thirdly, although the medical profession's present policy was formally stated in 1952, and restated in 1956, the American Medical Association has "challenged" the legislation authorizing non-service-connected care, not merely for a decade, but since 1925, the year after the World War Veterans Act was passed. That opposition was restated in 1926, 1927, 1928, and 1929. In 1930, the Board of Trustees approved

a letter sent by the General Manager to the Veterans' Bureau, protesting against construction of additional hospitals for non-service-connected care; at the June, 1930, session of the House of Delegates, a resolution was adopted recommending that indigent veterans be provided for by state, not federal, agencies.

In January 1933, a statement of A. M. A. policy was submitted to a Joint Committee of Congress which was studying veterans' care. Three A. M. A. representatives appeared before the Committee and went on record as opposing "the provision of free services to veterans whose disabilities are not service-connected." During the period from 1934 to 1951, numerous resolutions were introduced concerning veterans' care, as well as reports on the increasing proportion of non-service-connected care provided by V. A. hospitals and the increase in V. A. hospital construction. Some of these resolutions proposed improvements in methods of providing non-service-connected care as authorized by current legislation, but none of them nullified the Association's previously expressed belief that such care was not a proper federal responsibility.

In 1951, the Special Committee on Federal Medical Services was appointed, which conducted a year-long study of veterans' care and, in 1952, again stated the medical profession's belief that federal veterans' care should be limited to service-connected cases.

The concern over the medical care program for veterans with nonservice-connected disabilities is not, obviously, a new move on the medical profession's part; it has been expressed almost from the start of the program—not merely "during the past three years." Nor is it expressed merely because of a belief that the public is no longer interested—an important part of the medical profession's policy is to augment public interest in veterans' medical care.

Mr. Higley did, however, admit again that Congress should clarify and define the extent of federal responsibility for nonservice-connected care—which is, of course, just what the medical profession has been requesting for years.

Council on Medical Service—AMA

NOTE: Mr. Higley's resignation was accepted in mid-November, effective date not announced.

CORRESPONDENCE

Edwin W. Allen, Jr., M. D.
Swansea, South Carolina

January 7, 1958

Dear Dr. Waring,

Recently I have decided to move back to my old home in Milledgeville, Georgia. I should like to ask a favor of you in an attempt to get a doctor into this particular section of South Carolina. As you probably know both my family and I have a number of interests in middle Georgia—which is my reason for returning.

Swansea is in the "Sand Hills", only 21 miles south of Columbia. I am the only doctor between Cayce, S. C. and North, S. C. (north and south) and between St. Matthews and Leesville (east and west). Therefore my practice is not only in Swansea, but the communities of Gaston, Dixiana, Pelion, Macedon, Sandy Run and Woodford. I work in Lexington, Calhoun, Orangeburg, Aiken and Richland Counties. I am a staff member of the Columbia Hospital and the Baptist Hospital in Columbia.

Swansea is a town of some 1200-1500 people. Farming and a basket factory are the main industries. Many people live here and commute to Columbia and Orangeburg. A clothing factory is supposed to open here shortly.

We have an excellent school system here. The grammar school building is new as is the gymnasium. There are three large churches, the Baptist, Methodist and Lutheran.

One can determine one's income in this locality only by the amount of time that he is willing to work. I should say that \$20,000 gross would be expected for the first year. Since there is so much work, I feel that it would be better for two men to come into Swansea together. Each could have more time for himself and his family.

In my opinion some of the world's best hunting and fishing is in this section of the state. There are numerous private ponds in which the doctor is always welcomed. Dove shoots are held almost every day during the season. Quail have been plentiful this year. The Santee-Cooper is only about 30 minutes drive from here. The seacoast is only 1½ hours drive.

I shall appreciate anything that you can do to help me get another doctor (or two) in here. Certainly Swansea needs one.

Edwin W. Allen, Jr., M. D.

TO THE EDITOR:

I greatly appreciate your editorial effort for the Southern in the November Journal. However, I should like to straighten out a few points.

Interest in Southern is very much alive in South Carolina. We had four men on the Miami program from Greenville alone and there were others. Kenneth Lynch was awarded this year's distinguished service medal. Our membership is growing continually in South Carolina where we have nearly 400 members out of 10,000 in the entire South.

In my letter to you, which you so kindly published, I did not intend to be begging for the Southern; I was urging those who have not done so to become a living part of a great and lasting monument to our Association. I was asking our members in South Carolina to avail themselves of the opportunity of linking themselves in a very vital way to an organization which has a great and glowing future. Our home in Birmingham is virtually a *fait accompli*, and the names of all contributors (not the sum of the gift)

will be permanently recorded on the walls of the foyer.

Sincerely yours,
J. W. Jervey, Jr.
Greenville, S. C.

NEWS

EIGHTH DISTRICT MEDICAL SOCIETY HAS MEET

The Eighth District Medical Society of South Carolina held a supper meeting at the Hampton County Country Club November 27, with the Hampton County Medical Society serving as hosts for the affair. Dr. Carr T. Larisey of Hampton, is president of the District Eight Society. Dr. W. L. Young of Hampton, is secretary. They were in charge of arrangements for the district meeting.

Principal speaker was Dr. Kenneth Lynch, Jr. of Charleston, and his subject was "Injuries to the Urinary Tract". Also speaking briefly on the evening program was Dr. Cheves Smythe of Charleston, and his subject was "The Artificial Kidney".

Dr. W. W. King, Jr. of Batesburg has begun the practice of general medicine in Newberry.

Dr. King was graduated from the Medical College of South Carolina in 1956 and for the past year has been interning at Columbia Hospital in Columbia.

He is the son of Dr. and Mrs. W. W. King, Sr. of Batesburg.

Iverson O. Brownell, M. D. and Joseph J. Nannarello, M. D. have announced their association for the practice of Neuropsychiatry, 610 Pendleton Street, Greenville.

AMERICAN COLLEGE OF SURGEONS

Dr. Furman Wallace of Spartanburg is the new president of the South Carolina chapter of the American College of Surgeons.

He was elected November 22 at the eighth annual meeting held in conjunction with the South Carolina Society of Anesthesiologists at Greenville General Hospital.

Other officers are Dr. Asa Scarborough of Greenville, vice president, and Dr. David Watson of Greenville, secretary-treasurer. The new president succeeds Dr. Alton Brown of Rock Hill.

Present officers of the Society of Anesthesiologists, who will serve until May, are Dr. John Doerr of Charleston, president; Dr. James Duncan of Spartanburg, vice president; and Dr. Ray Ivester of Charleston, secretary-treasurer.

Dr. G. E. McDaniel attended the meeting of the Southern Medical Association, serving as vice-chairman of the Public Health Section. At this meeting

Dr. McDaniel was elected chairman of the Public Health Section to serve during the coming year.

Dr. James E. Rountree, Aiken surgeon, has been named a Fellow of the American College of Surgeons. Doctor Rountree has successfully met the requirements for membership in the college through his education, training and practice. He is a graduate of the University of Georgia and the Georgia School of Medicine in Augusta. The Aiken surgeon is a native of Metter, Ga.

DR. HAL HOLMES

Presentation of the Citizen's Distinguished Service Award plaque and an address by Senator James Stevens of Horry County, highlighted the annual Veteran's Day activities held in Conway in November.

Dr. Hal B. Holmes was presented the plaque by Gene McCaskill

Following is the summary as presented to the crowd attending the Veteran's Day Program:

By the high caliber of his professional services and his sterling worth as a citizen, Dr. Hal B. Holmes has endeared himself to residents of Conway and Horry County. As a foremost member of the medical profession in Conway, where he has maintained offices for more than thirty years specializing in the practice of surgery, he has had the mind and soul of a true physician. Uppermost in the life and work of Dr. Holmes is the pure joy of healing and the constant realization of his responsibility when dealing with the sick. Throughout the years he has met with gratifying success.

Hal B. Holmes was born on April 30, 1898 in the Good Hope Community of Horry County, South Carolina.

He was graduated from the Burroughs High School in Conway with the Class of 1917, where he was valedictorian and president of the Senior Class. He enlisted in the U. S. Navy for service in World War I, and served in the Atlantic and North Sea theater of operations for two years and two months. Upon his return from the Navy he completed his pre-medical studies in three years as an honor graduate at the University of South Carolina, while teaching and working his way through college. He then entered the Medical College of South Carolina, graduating in 1926.

After interning at Roper Hospital, Charleston, Dr. Holmes began active private practice at Conway. During the following years he has kept abreast of the ever changing developments in medicine and surgery by doing post-graduate work in New York and the Charity Hospital, New Orleans. He is a member of the surgical staff of the Conway Hospital and serves on its board of directors. In the establishment of the Conway Hospital Dr. Holmes labored faithfully in every capacity, often relinquishing his professional fees and contributing to current bills to keep the

small hospital going. In addition to his services as surgeon and physician, Dr. Holmes served as the only radiologist at the institution for many years.

Dr. Holmes is now president of the Horry County Medical Society and belongs to the Pee Dee Medical Association, the South Carolina Medical Association, the Tri-State Medical Society, and the American Medical Association.

Beloved by all, Dr. Holmes, as a true family physician, has contributed immeasurably to his compassion for his fellow man and his zeal for his profession. Actual records of the county show that Dr. Holmes has cared for more than half the indigent of his community with no thought of compensation, save in the hearts of those to whom he ministered. His cheery bright manner, cordial to all, overlooking none with whom he comes in contact as he goes whistling through the corridors of the Conway Hospital, has dispelled the gloom and care of countless numbers as he treats both soul and body.

Dr. L. E. Kirven has opened an office in West Columbia for the practice of General Medicine.

The location of Dr. Kirven's office is in the east wing of the Carolina Rest Home on U. S. Highway No. 1.

ABSTRACT

A New External Cutter in Varicose Vein Surgery by Richard S. Wilson, M. D., Furman T. Wallace, M. D. and Walter Thompson, M. D. (Spartanburg) American Surgeon 23:917, October, 1957.

A technique using a new extraluminal cutter over an intraluminal guide supplemented by direct excision is recommended in the surgical treatment of primary varicose veins. It is now well established that the optimum treatment is high saphenous ligation with securing of the tributaries and removal of the diseased superficial veins.

A cylindrical cutting head 1 cm. in diameter has been mounted on a long shaft. After an intraluminal flexible stripper has been inserted into the vein as a guide, the extraluminal cutter is passed over the vein and cleanly divides the communicators and perforators at their junction with the main saphenous trunk. This permits easy removal of the entire vein from the groin to the ankle. The hazard of deep venous thrombosis and mutilation of long segments or vessels by blunt avulsion is avoided by the sharp cutter. The combined technique has the advantages of reducing operating and anesthetic time, permitting treatment of both extremities at one time. Quick removal of the saphenous trunks by stripping leaves operating time for direct dissection and excision of remaining venous variations.

RADIATION HAZARDS

I was amazed to learn that many well known maternity hospitals still insist on routine thymus plates on all newborn and x-ray treatment if a thymus

shadow is visualized. This seems incredible. Certain young pediatricians who object to the procedure on arriving in a community find that they are referred no babies until they comply. I would be more than interested if anyone who has knowledge of this practice in his area would send me a personal note with details. I will not use names, but the assembled information would carry weight.

"Routines" are responsible for much unnecessary exposure. One member called our age the "Era of Ruling Out". This ruling out philosophy has become too great a part of medical thinking to the exclusion of sound proven medical principles that dictate the importance of a good history and physical examination. Examples of current "Routines" were given:

The routine G. I. series ordered stat in every vomiting baby.

The routine photofluorogram ordered on every admission as he passes thru the admitting room, to be followed the next day by routine 14 x 17 flat films.

The routine photofluorograms on all personnel.

The routine photofluorogram or conventional films on all pregnant women.

The routine x-ray pelvimetry on all pregnant women.

The routine x-ray dental survey in both mothers and children.

The routine frequent follow-up films on medical and orthopedic conditions beyond the number actually indicated.

The unnecessary radiation of mothers and children from dental x-rays deserves special mention. A survey of dental x-ray machines revealed one-third were bad, one-third were not good, and one-third were good from the point of view of calibration, shielding, seat-ter, etc. Many had no filters, diaphragms or lead shields. One physician placed a cassette behind his head while a dental survey was being made. When developed, he had a perfect x-ray picture of his entire skull. Many dental films are taken with the target directed directly at the gonads. An approved x-ray machine with proper filters and diaphragm, with the patient shielded will deliver a very tiny dose to a sharply defined jaw area. The dentists themselves are properly concerned, not only for their patients, but also because they themselves have been receiving unnecessary x-ray exposure over many years.

News Letter—Amer. Acad. of Pediatrics

FOGARTY SEES ACTION ON SOME FORM OF FORAND BILL THIS YEAR

Rep. John Fogarty (D., R. 1.), chairman of the House subcommittee that handles appropriations for nearly all U. S. health programs, predicts that Congress will vote a program of federal assistance to the aged for their hospital needs in 1958. The major bill on this subject is sponsored by a fellow Rhode Island Democrat, Rep. Aime Forand. It would amend the

social security system to permit the aged social security beneficiaries and their dependents and survivors to get free hospitalization and surgical services. The bill has the official support of the 13½-million member AFL-CIO.

Speaking to a meeting of the Washington chapter of the National Association of Social Workers, Mr. Fogarty cited several reasons for his belief that Congress would enact some legislation on hospitalization for the aged: (1) growing unemployment, which he feels may reach 6 million by next March, will put pressure on legislators to do something, and (2) it is an election year. The Forand bill can be amended, he said, and the final measure may not resemble it as now written.

The Rhode Island congressman also favors increasing monthly social security benefits, reducing the retirement age for both men and women to 60 and making social security payments available to the disabled regardless of age.

The AFL-CIO at its annual convention urged liberalization of social security, indorsed the Forand bill and proposed a 10-year extension of the Hill-Burton hospital construction program.

II. H. Addlestone, M. D., announces the association of Alfred E. Rawl, Jr., M. D., in the practice of Radiology at St. Francis Xavier Hospital, Charleston.

MEDICAL RESEARCH FOUNDATION ESTABLISHED FOR TAY-SACHS' DISEASE AND ALLIED DISORDERS

A new non-profit foundation has been established to support and stimulate research, clinical, and educational programs in Tay-Sachs' disease and allied heredo-familial, neuro-degenerative diseases of infancy and childhood. The scope of the program will include, in addition to Tay-Sachs' disease, Niemann-Pick's disease, infantile Gaucher's disease, Schilder's disease, diffuse sclerosis, amyotonia congenita, Friedreich's ataxia, and others. The foundation is known as National Tay-Sachs Association, Inc., New York Chapter, and is composed of parents who have had afflicted children, interested laymen, and medical personnel in the field.

The foundation is cooperating with the existing clinical and research program on Tay-Sachs' disease and certain of these allied diseases at Jewish Chronic Disease Hospital in Brooklyn, New York. The hospital is at present conducting a special clinic for outpatient care of afflicted children, and is constructing a special ward for the care and observation of inpatient cases. Both of these programs are being conducted in conjunction with the laboratory research program of the Isaac Albert Research Institute of the hospital. A comprehensive genetic study is also being made of the pertinent hereditary patterns from histories supplied by the foundation and parents who have children under the care of the hospital. A counseling program is also offered.

The operation of the foundation is on a nationwide basis, and contact is being made for establishment of chapters in other metropolitan areas, in addition to the allied Tay-Sachs Association in Philadelphia. In order to further its work and, in particular, to prepare a substantial genetic study covering the entire country, physicians and hospitals are respectfully requested to make the existence of the foundation known to parents of children afflicted with these diseases.

For further information on the foundation and its work, write to Medical Committee, National Tay-Sachs Association, Inc., New York Chapter, P. O. Box 1250, G. P. O., New York 1, N. Y.

The Foundation is not primarily interested in the solicitation of funds through campaigns, but is more concerned with (1) interesting physicians, hospitals, medical centers, and medical schools in the field of heredo-familial neuro-degenerative diseases occurring in infancy and childhood, and encouraging them in doing research in this field, and (2) in acting as a central clearing house or registry for those families which have had, or have infants and children with these diseases, and thus collect full case histories which will be available for complete genetic studies. All money which will be received is solely for research purposes. The Foundation has no paid employees. In lieu of any solicitation of funds from the general public, The Foundation traces down and locates sources of medical grants which interested physicians and researchers can make application for.

Henry C. Heins, Jr., M. D. and Thomas G. Herbert, Jr., M. D. announce the removal of their offices to 59 Bee Street, Charleston.

Seven million dollars have been contributed today by the Government of the United States to the heads of the World Health Organization and the Pan American Sanitary Organization in furtherance of the work of those international agencies in assisting governments throughout the world to eradicate malaria.

Infecting some 250,000,000 persons each year, malaria is still the most prevalent and most costly disease in many countries, in its toll of human lives and suffering, and in its social and economic effects on nations and people. In recognition of this situation, and armed at last with effective weapons to combat it (the residual insecticides such as DDT to destroy the mosquito vectors that spread it), concrete planning was initiated a few years ago for its eradication. At its XIV Conference in Chile in 1954, the Pan American Sanitary Organization launched the first such program in a major area of the world, aimed at the eradication of malaria from the Americas.

In a similar action taken in Mexico in 1955, the VIII World Health Assembly extended the eradication program to embrace the whole world. The special Malaria Eradication Funds were set up outside the regular budgets of WHO/PASO to help meet the considerable cost of this work. The Organizations in-

vited voluntary contributions to these Funds, over and above the regular, assessed quota payments made annually by their member governments. —There are 88 nations, members of WHO; the PASO includes as members the 21 American republics and France, the Netherlands and the United Kingdom on behalf of their territories in the Western Hemisphere.—

THE FORD FOUNDATION
Privately Supported Hospitals
Receiving Final Grants and Payments During
The Year Ended September 30, 1957

	1957 Payments	Total Grants
South Carolina		
Anderson County Hospital, Anderson	63,200	126,400
St. Mary's Hospital, Anderson	5,000	10,000
Marlboro County General Hospital, Bennettsville	19,700	39,400
Camden Hospital, Camden	19,100	38,200
Baker Memorial Sanatorium, Charleston	13,700	27,400
Roper Hospital, Charleston	123,750	247,500
St. Francis Xavier Hospital, Charleston	29,550	59,100
Good Samaritan-Waverly Hospital, Columbia	14,750	29,500
Providence Hospital, Columbia	28,150	56,300
Ridgewood Tuberculosis Sanatorium, Columbia	13,550	27,100
South Carolina Baptist Hospital, Columbia	67,250	134,500
Conway Hospital, Conway	23,050	46,100
St. Eugene Hospital, Dillon	13,950	27,900
McLeod Infirmary, Florence	51,250	102,500
Saunders Memorial Hospital and Clinic, Florence	17,150	34,300
Georgetown County Memorial Hospital, Georgetown	14,150	28,300
Greenville General Hospital, Greenville	250,000	250,000
Shriners Hospitals for Crip- pled Children, Greenville	17,750	35,500
St. Francis Hospital, Greenville	27,750	55,500
Self Memorial Hospital, Greenwood	27,750	55,500
Byerly Hospital, Hartsville	25,000	50,000
Joanna Memorial Hospital, Joanna	5,000	10,000
Kelley Memorial Hospital, Kingstree	9,550	19,100
Marion Sims Memorial Hospital, Lancaster	18,050	36,100
Berkeley County Hospital, Moncks Corner	7,850	15,700
Newberry County Hospital, Newberry	11,550	23,100

Cannon Memorial Hospital, Pickens	27,100	27,100
Ridgeland Hospital, Ridgeland	6,600	13,200
St. Philip's Mercy Hospital, Rock Hill	19,500	39,000
Oconee Memorial Hospital, Seneca	15,650	31,300
Mary Black Memorial Hos- pital, Spartanburg	11,050	22,100
Community Hospital, Sumter	5,000	10,000
Tuomey Hospital, Sumter	35,050	70,100

ANNOUNCEMENTS

The Southeastern Surgical Congress will hold its Twenty-sixth Annual Assembly in Baltimore, March 10, 11, 12, 13, 1958. Among the speakers will be Dr. Edward F. Parker of Charleston who will talk on "A Measurement of the Contractile Force of the Ventricle During Cardiopulmonary By-pass", and Drs. J. Manly Stallworth, William H. Lee, Charles Belisle, and Daniel B. Nunn of Charleston, who will present a paper on "A Clinical Comparison of the Effects of Commonly Used Vasodilator Drugs on Arterial Diseases".

GREENVILLE POST GRADUATE
SEMINAR

April 1, 2, & 3, 1958

Greenville General Hospital

The Greenville Post Graduate Seminar will have its annual program at the Greenville General Hospital April 1, 2, and 3, 1958. The following honored guests will have part in the Seminar and the Seminar feels very grateful to have them take part in this program. Among those attending will be:

- Dr. Edgar Hull—Louisiana State University School of Medicine
Dr. Peter Gazes—Medical College of South Carolina
Dr. Ben Gendel—Emory University
Dr. Claude Frazier—Asheville, North Carolina
Dr. Jack Norris—Atlanta, Georgia
Others attending from the Medical College of South Carolina will be Dr. John Cuttino, Dr. Fred Kredel, Dr. John Siegling, and Dr. Ed Boyle.

On Wednesday evening, the second of April, a banquet will be held at the Greenville Country Club in conjunction with the meeting of the Greenville County Medical Society.

It is expected that eighteen hours of category one accreditation by the American Academy of General Practice, will be granted this Seminar.

ACADEMY OF GENERAL PRACTICE
MEETS NEXT MARCH IN DALLAS

The American Academy of General Practice Tenth Annual Scientific Assembly will give more than 8,000

family doctors, residents, interns and guests an opportunity to hear 35 medical experts discuss subjects ranging from teen-age problems to old-age problems and from heart disease and ulcers to eye ailments, fractures and the hypnotized patient. The four-day Assembly opens March 24 in the new Dallas Memorial Auditorium.

More than 90 scientific and 300 technical exhibits will supplement the scientific lecture program.

Special activities are planned for the Academy's tenth anniversary Assembly.

The International Society of Internal Medicine has announced that its Fifth International Congress of Internal Medicine will be held at the new Sheraton Hotel, Philadelphia, Pennsylvania, April 24-26, 1958. This will be the first meeting of the Society outside of Europe.

At the Philadelphia Congress it is planned, through lectures and panels, to analyze medical achievements of world-wide significance, to evaluate certain apparent problems and to chart courses of action designed to enhance technical knowledge and to aid in the continuing war against disease. At the same time, the plan includes such social and cultural activities as will tend to promote cooperation, friendship and mutual understanding among physicians and peace among their countries.

The 1958 Annual Session of the American College of Physicians will occur in Atlantic City, April 28 to May 2, immediately following the Philadelphia Congress. The members of the Congress are invited to attend all the scientific programs and extensive exhibits (the foreign members on a purely courtesy basis).

The World Congress of Gastroenterology and the 59th Annual Meeting of the American Gastroenterological Association will be held in Washington, D. C., U.S.A., at the Sheraton Park Hotel, May 25th to 31st inclusive, 1958. The scientific meetings of the Congress will occupy Sunday, Monday, Tuesday, Wednesday and Thursday and the 59th Annual Scientific Session of the American Gastroenterological Association will take place Friday and Saturday. The objective of this Congress is to bring together scientists, from all parts of the globe, who are actively contributing new knowledge and experience in the fundamental sciences or in the clinical behavior patterns related to disorders of the alimentary tract.

PAN AMERICAN MEDICAL WOMEN'S ALLIANCE SIXTH CONGRESS — MIAMI, FLORIDA McALLISTER HOTEL, APRIL 14-17, 1958

The Department of Psychiatry of the University of North Carolina School of Medicine (Dr. George C. Ham, Professor and Chairman of the Department and Dr. Lucie Jessner, Professor and Director of the Child

Psychiatric Section) announces the opening on February 1, 1958, of a nine bed Child Psychiatric Inpatient Service in the North Carolina Memorial Hospital for intensive diagnostic evaluation and short term therapy of emotionally disturbed children under twelve years of age. Children may be referred as private or as staff patients from North Carolina and as private patients from other states. Inquiries should be addressed to the Admissions Officer, Psychiatric Center, N. C. Memorial Hospital, Chapel Hill, North Carolina.

POSTGRADUATE COURSE ON DISEASES OF THE CHEST

The Council on Postgraduate Medical Education of the American College of Chest Physicians will sponsor the Fourth Southern Postgraduate Course on Diseases of the Chest at Grady Memorial Hospital, Atlanta, Georgia, March 10-14, 1958.

The most recent advances in the diagnosis and treatment of chest diseases—medical and surgical—will be presented. The tuition fee is \$75 including round table luncheons.

The Fifth International Congress of Internal Medicine which is to be held in Philadelphia on April 23-26, 1958.

The second annual Post Graduate Course in FRACTURES AND OTHER TRAUMA will be given by the Chicago Committee on Trauma of the American College of Surgeons, for four days from Wednesday, April 16 through Saturday, April 19, at the John B. Murphy Memorial Auditorium, 40 East Erie Street, Chicago.

SOCIAL SECURITY SAYS: "It is common knowledge that most of us because of living costs, social standards, and economic misfortunes, do not set aside enough money or other assets during our working years to provide adequately for ourselves or our families when earned income is cut off by disability, old age, or death."

In Other Words: Social Security believes that "most of us" must depend upon the government in our "hour of need."

SOCIAL SECURITY SAYS: "Your social security taxes pay for these nine programs:

Social Insurance

(a) Unemployment insurance

(b) Old Age and Survivors Insurance

Public assistance to the needy

(a) Old-age assistance

(b) Aid to the needy blind

(c) Aid to dependent children

(d) Aid to the permanently and totally disabled

Children's services:

(a) Maternal and child-health services

(b) Services for crippled children

(c) Child-welfare services

In Other Words: In spite of the fact that most of these represent federal grants to state aid, this Social Security program is being sold to you and me as "contributory social insurance."

SOCIAL SECURITY SAYS: "The following table shows the present tax rates and the scheduled increases: (on \$4200 wage base)

Calendar year	Employee	Employer	Self-Employed
1956 -----	2%	2%	3%
1957-59 -----	2-1/4%	2-1/4%	3-3/8%
1960-64 -----	2-3/4%	2-3/4%	4-1/8%
1965-69 -----	3-1/4%	3-1/4%	4-7/8%
1970-74 -----	3-3/4%	3-3/4%	5-5/8%
1975 and after	4-1/4%	4-1/4%	6-3/8%

In Other Words: A recent announcement stated that the Social Security system is in trouble. Benefit funds are melting as applications pour in at a rate in excess of Federal estimates. HEW Secretary M. H. Folsom was quick to say that expenditures may exceed income in 1959, but higher taxes in 1960 will cover the deficit. Check the chart above for proof that our children will be paying the bills for our benefits.

1. The American Hospital Association is convinced that retired aged persons face a pressing problem in financing their hospital care.

2. It believes that federal legislation will be necessary to solve the problem satisfactorily. It has, however, serious misgivings with respect to the use of compulsory health insurance for financing hospital care even for the retired aged.

3. It believes that all possible solutions must be vigorously explored including methods by which the dangers inherent in the Social Security approach can be avoided.

4. It believes that the use of Social Security to provide the mechanism to assist in the solution of the problem of financing the hospital needs of the retired aged may be necessary ultimately. However, it believes that every realistic effort should first be made to meet these needs promptly through other mechanisms utilizing existing systems of voluntary prepayment.

AMA News Letter

THE CONSULTANT'S REPORT

Re: Mrs. Blatz

Dear Doctor:

Rummaging in my desk today I came across a folder which reminded me that I had not reported to you on the patient, Mrs. Blatz, whom you sent to me several months ago. I am sure you will understand that we consultants to whom important cases are referred find it difficult to get our thoughts collected promptly, and naturally we are not bothered, as you would be, by the importunities of the patient and family in reference to the urgent situation which you and I discovered.

The above-captioned patient (whatever that means) was seen by me after an exhausting series of tests ranging from the Abderhalden reaction to Zange-meister's test. A number of these tests were slightly positive, while others which were repeated were contradictory to themselves for some strange reason, and we were finally driven to pouring the liquid elements into the sink and the solids into the usual receptacle. During this process it was discovered that the patient was still alive, and strenuous efforts were made to revive her to the point that a physical examination could be done. As the event seemed doubtful, we quickly repeated all our tests, maintaining the patient in an iron lung with the help of oxygen and a number of the latest stimulant drugs, and finally we were able to make rapid but minute examination of all of the several systems, ruling out this and ruling out that in very short order. After all the ruling out, the patient was found to have an extremely unusual condition, a single case of which has been described by Kunkel, Furstenburger, Gerstenberger, and Klunk in the Zeitschrift für Pure Balogny, Vol. 58, p. 299. We would like very much to have investigated this condition further, but as the patient had already exhausted all her insurance and such funds as she could beg, borrow, or steal, we were forced to discharge her with her condition incompletely diagnosed.

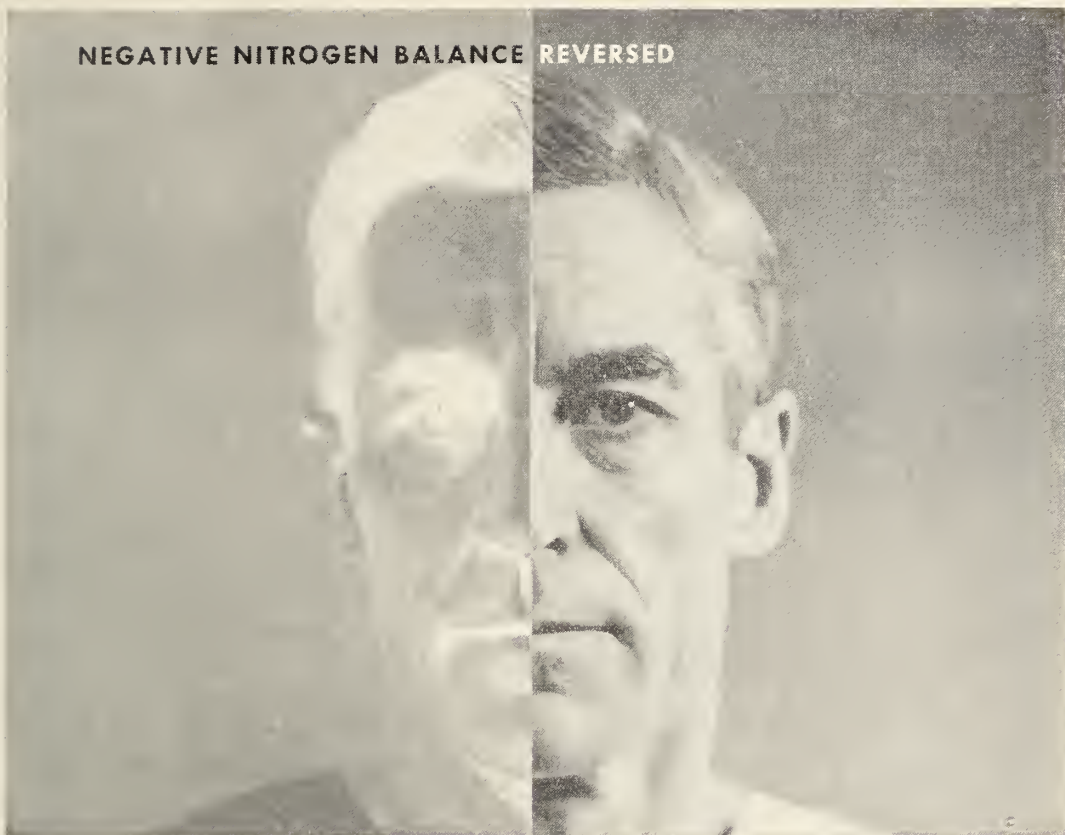
After her recovery from her examination, she was sent home to convalesce from her experience, and we would like very much to have daily reports on her progress.

Enclosed herewith is a 16-page single-spaced, electrically typed report in which we conclude in well chosen vague phrases that this is an extremely interesting case and that we will agree fully with your diagnosis whenever it may be made.

Yours in science,



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Increased nitrogen loss, with resulting negative nitrogen balance, occurs in infection, trauma, major surgery, extensive burns, certain endocrine disorders and starvation and emaciation syndromes. The intrinsic control of protein metabolism is lost and a protein "catabolic state" occurs. A patient requiring more than ten days of bedrest usually has had sufficient metabolic insult¹ to precipitate such a "catabolic" phase.

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The suggested adult dosage is three to five tablets (30 to 50 mg.) daily. For children 1.5 mg. per kilogram of weight is recommended.

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Research in the Service of Medicine.

1. Axelrod, A. E.; Beaton, J. R.; Cannon, P. R., and others: Symposium on Protein Metabolism, New York, The National Vitamin Foundation, Incorporated, (March) 1954, p. 100.

2. Proceedings of a Conference on the Clinical Use of Anabolic Agents, Chicago, Illinois, G. D. Searle & Co., April 9, 1956, pp. 32-35.

SEARLE

BOOK REVIEWS

FUNDAMENTALS OF GENERAL SURGERY, John A. Guis, M. D., pp. 720; illus. 275, Year Book Publishers, Chicago, 1957. Price \$12.50.

It is refreshing to see a text on surgery of ordinary size and weight. By omitting profuse detail and variation, the author has condensed the principles of surgery into a compact and readable volume. For those desiring more information from any chapter, a list of suggested readings from the current literature is appended. This should be a useful book for the student and house officer as well as for the doctor in practice.

Fred Kredel, M. D.

GIFFORD'S TEXTBOOK OF OPHTHALMOLOGY: By Francis H. Adler, M. D., Wm. F. Norris and George E. DeSchweinitz. Sixth edition. 277 figures and 26 color plates. W. B. Saunders Company, Philadelphia. Price: \$8.00.

The sixth edition of this text upholds the excellence in all respects exhibited in previous editions.

Dr. Adler's readable prose and easy style, together with his usual scholarly thoroughness, gives one who reads it, not only valuable knowledge but much pleasure.

The addition of the chapter on ocular injuries in this sixth edition adds much to the practical usefulness of this book.

A medical student now using it as a text will value it also as a permanent addition to his medical library of the future. Others in general practice and in ophthalmology welcome this newest edition of a well known text book by its much esteemed and brilliant author.

Pierre G. Jenkins, M. D.

GOEPP'S MEDICAL STATE BOARD QUESTIONS AND ANSWERS, by Harrison F. Flippin, M. D., University of Pennsylvania. Editorial Consultants: William S. Blakemore, M. D.; Jefferson H. Clark, M. D.; George M. Eisenberg, D. Sc.; George L. Hoffman, M. D. Ninth edition. 569 pages. W. B. Saunders Co., Phila. Price: \$8.00.

This is an "old reliable" product which gives in abbreviated form the essentials of medicine and the questions which the candidate is apt to encounter on state board examinations. It is in effect a compendium of condensed medical knowledge and offers anyone a means of rapid review of a subject. The new graduate will find it most useful.

J. I. W.



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South Carolina Medical Association

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THE ETIOLOGY AND TREATMENT OF ACQUIRED AORTIC VALVULAR INSUFFICIENCY

ONE CASE REPORT TO REPRESENT EACH MAJOR ETIOLOGICAL
CLASSIFICATION*

J. MANLY STALLWORTH, M. D., DANIEL B. NUNN, M. D.**, JOHN A. BOONE, M. D.

Introduction

The very great majority of cases of aortic insufficiency seen by the practicing physician are caused by syphilis or rheumatic fever. In the Southern states syphilis is the predominant etiological factor although it is becoming known that rheumatic fever is a far more common cause than suspected in previous years. The reverse is true in the Northern states where the cases are predominantly caused by rheumatic fever and syphilis is a minor factor. Much less commonly, there may be congenital defects of the structure of the aortic valve or mechanical damage to the valve through rupture secondary to a severe strain, or by weakening of the valve from erosion by bacterial endocarditis. Other rare causes are dissection of the aorta as a result of atherosclerosis or the congenital medial weakening in Marfan's syndrome. Occasionally in hypertensive patients, particularly those with high diastolic blood pressure, slight to moderate murmurs of aortic insufficiency appear, but these may be looked upon as functional murmurs since they never result in a

clinically significant degree of regurgitation.

In the majority of cases, however, aortic insufficiency, whatever the etiology, is a lesion of major significance. In the usual case of rheumatic aortic insufficiency the ability of the left ventricle to undergo compensatory hypertrophy enables the heart to maintain compensation for a characteristically long time before progression of the leak finally results in exhaustion of the myocardium and resultant congestive heart failure. In syphilitic aortic insufficiency, on the other hand, unless arrested in its earliest stages by adequate antisiphilitic therapy, the insufficiency runs a rapid course between the first appearance of the murmur and the appearance of gross congestive heart failure. An even more rapid downhill course is seen in cases of traumatic or ulcerative rupture of aortic valves.

For a time, most cases of congestive failure due to aortic valve insufficiency respond fairly well to the usual administration of digitalis and diuretics. The response to medical treatment is in general, however, less likely to be as effective or as long-lasting as in congestive failure from other causes. The development of mechanical devices for the relief of severe aortic regurgitation is therefore a very distinct advance in the relief of these cases when they have reached the end of their medical rope.

*These patients and this work were supported by the S. C. Heart Association.

**Fellow Cardiovascular Service, Medical College of South Carolina.

From Department of Medicine and Surgery, Medical College of South Carolina, and Roper Hospital, Charleston, South Carolina.

Within recent years, an acceptable surgical procedure, based upon the insertion of a plastic ball valve into the descending aorta, has been developed by Hufnagel¹ for the treatment of certain patients with aortic insufficiency. This procedure, while not completely corrective, has afforded in the majority of instances significant relief of symptoms to those patients failing to respond to usual medical therapy.^{1,2} The following account is concerned with a discussion of this means of surgical treatment and a report of four illustrative cases of varying etiology treated in this manner at the Medical Center Hospitals.

Surgical Treatment

Over the past few years, several experimental approaches have been tried in an effort to develop a satisfactory corrective surgical procedure for aortic insufficiency. Unfortunately, the majority of these efforts have failed to yield any promise for long-term good results. Examples of such efforts are the use of homologous transplants of either the pulmonary or aortic valve,¹ reconstruction of a valve from segments of pericardium, veins, arteries, or a combination of the structures,¹ the use of a transvalvular stent constructed of a segment of costal cartilage wrapped in pericardial tissue,³ and the use of a nylon sash ligature placed around the aortic annulus.³

In 1954, after preliminary experimental suc-

cess, Hufnagel¹ reported on the clinical use of a plastic ball valve placed in the descending aorta for the treatment of aortic insufficiency. This valve (Figure 1) is constructed of a single piece of methyl methacrylate with a contained ball which was originally constructed of similar material or polyethylene. Recently, the ball has been constructed of a hollow nylon sphere coated with Silastic (a rubber-like substance) in order to obviate the noise which was produced by the earlier model of the valve. The valve is available in four sizes ranging from 3/4 inch to 1-1/8 inch inside diameter made to meet the requirements of the different sizes of human aorta encountered. Once the valve is inserted into the proximal and distal severed ends of the descending aorta, fixation is accomplished by means of a nylon ring, with multiple teeth projecting from its inner surface, placed around the aorta and each end of the valve. The purpose of this "multiple point fixation" is to avoid complete circumferential pressure with subsequent necrosis of the segment of aorta projecting beyond the nylon rings. These rings in turn are held in place by a heavy silk ligature which lies in a groove around their circumference. Additional support is gained through the use of a twisted wire placed through the two holes in the body of each ring.

The rationale for inserting the plastic valve in the descending aorta is found in the results of experimental work designed to determine the optimal location of an artificial valve which could reduce the greater portion of regurgitant blood flow without decreasing the proximal diastolic pressure to the point of compromising coronary filling. In short, it was found that a plastic valve placed in the descending aorta immediately distal to the left subclavian artery would prevent approximately 75 per cent of aortic regurgitation and at the same time allow for adequate coronary filling by reflux of blood from the vessels proximal to the valve.

Since the Hufnagel procedure is not a totally corrective one, only those patients with aortic insufficiency who have experienced some degree of decompensation are considered candidates for operation. Consequently, the morbid-



FIGURE 1

"Aortic valvular prosthesis with its "multiple point fixation" rings.

ity and operative mortality are necessarily higher than in those forms of heart disease that produce symptoms early and are amenable to surgical treatment. Hufnagel, with the largest series of cases, reports an operative mortality of 20% in a group of 80 patients; the majority of deaths being due to ventricular fibrillation.² In general, the results of operation have been those of improvement except for the limitations imposed by irreparable myocardial changes occurring prior to operation. No instances of failure of the valve to function post-operatively have been reported to date.

Case Reports

Case I: (Ruptured Leaflet) A 20 year old white male⁴ was admitted to Roper Hospital on January 16, 1955 with complaints of exertional dyspnea, orthopnea, and paroxysmal nocturnal dyspnea. His present illness dated back to December, 1953, when he first experienced sudden pain in the chest and left arm, exertional dyspnea, and pedal edema following a physical act of exertion. Prior to this time he had been lifting and handling heavy materials without difficulty while working full-time at a textile mill. In March, 1954, he was admitted to the Spartanburg General Hospital because of severe congestive heart failure associated with hypertension. He responded to digitalis and diuretics, but on discharge continued to have exertional dyspnea and was forced to give up his job. In December, 1954, he was re-admitted to the Spartanburg General Hospital with increasing signs of heart failure and chest pains. At that time a diagnosis of coarctation of the aorta was made, and the patient referred to Roper Hospital for operative treatment.

Physical examination on admission to Roper Hospital revealed a well-nourished, well-developed white male who appeared to be slightly dyspneic while sitting in bed. The blood pressure was recorded as 220/80 in each arm and 150 in the right leg and 144 in the left leg by palpation. The brachio-cephalic pulses were "water-hammer" type, while pulsations in the lower extremities were barely palpable. The heart was enlarged and a marked precordial heave was present. A Grade III blowing diastolic murmur was audible at a point just to the right of the sternum in the third intercostal space and to a lesser degree along the left sternal border. The liver was palpable four to five cm. below the right costal margin. X-ray films, which included cardiac fluoroscopy and angiocardiograms, were consistent with the diagnosis of coarctation of the aorta with aortic regurgitation. Cardiac catheterization performed on the right side of the heart was unremarkable except for a right ventricular pressure of 70/10 mm of mercury. An ECG revealed changes of left ventricular hypertrophy and delayed IV and AV conduction times. Wasserman and Kline examinations were reported as negative. The final

clinical impression was coarctation of the aorta and aortic insufficiency, thought to be secondary to traumatic rupture of an aortic cusp.

On January 24, 1955 the patient underwent left thoracotomy. A coarctated segment of the aorta, measuring 0.5 cm. in diameter at the smallest point was present immediately distal to the left subclavian artery. Because of the associated aortic regurgitation, it was decided to insert a Hufnagel valve following resection of the area of coarctation. In order to accomplish this, it was necessary to also insert an aortic homograft between the proximally divided aorta and the proximal end of the Hufnagel valve because of the close proximity of the coarctation to the origin of the left subclavian artery. The patient withstood the operative procedure satisfactorily, and the post-operative course was uncomplicated except for a mild phlebitis at the site of a venesection. The post-operative blood pressure was recorded as 130/20 in the arms and 130/80 in the legs.

Since his discharge, the patient has returned to work on an eight hour schedule, and does not experience dyspnea on moderate exertions. The heart size is now smaller, but the murmur of aortic insufficiency is unchanged.

Case II: (Syphilitic Valvulitis) A forty-three year old colored male was admitted to Roper Hospital on February 4, 1955, with the chief complaint of progressive dyspnea for the past 6 to 8 months. Within the past three weeks prior to admission to the hospital the dyspnea had become particularly severe and was present even at rest. Associated symptoms included increasing weakness and non-productive cough. There was history of a positive Wasserman and Kline in 1952, following which the patient was treated with a series of 15 injections of penicillin.

Physical examination on admission revealed a well-developed and well-nourished colored male who appeared dyspneic while sitting in bed. The blood pressure was recorded at 128/10 in the arm and the pulses described as "water-hammer" type. A regular sinus rhythm was present. The heart was enlarged to the left and a Grade IV blowing diastolic murmur was audible at the primary aortic area. A soft systolic and a questionable low pitched diastolic murmur were detected at the mitral area. Moist rales were present in both lung bases. X-ray films of the chest were reported as showing cardiomegaly involving primarily the ventricular segment. An ECG revealed changes consistent with left ventricular hypertrophy. A Wasserman and Kline determination was reported as positive. Final clinical impression was aortic insufficiency secondary to syphilitic aortitis. Operative treatment with insertion of Hufnagel valve was advised because of the rapid progression of cardiac difficulties.

On March 3, 1955 left thoracotomy was performed with insertion of a Hufnagel valve into the proximal descending thoracic aorta. The patient withstood this procedure well, and the post-operative course was uncomplicated. At the time of discharge, the blood pres-

sure was recorded at 125/0 in the left arm and 180/120 in the left leg.

Since operation the patient has remained well-compensated and is able to walk four blocks without becoming dyspneic. The heart is still enlarged although there has been a slight decrease in size. Approximately one year after operation, the patient was hospitalized following an embolus to the right popliteal artery. He was treated with anticoagulants without loss of the extremity and has not experienced further embolic episodes even though anticoagulants have been discontinued.

Case III: (Rheumatic Valvulitis) A 39 year old white male was admitted to Roper Hospital on January 23, 1955. He gave a history of having been in apparent good health until 19 months previous to this admission when he began to experience dyspnea on exertion and angina-like pains. In spite of this, he had gotten along fairly well until April, 1954 when the dyspnea progressed to orthopnea, chest pains increased in severity, and ankle edema became manifest. He was in a hospital in Augusta, Georgia at this time, and was diagnosed as having rheumatic heart disease. His general condition improved somewhat with digitalis and diuretics, but there was no decrease in the severity of chest pains. Over the next few months he required admission to the hospital on several occasions, and continued to have the severe chest pains. Because of this progression of symptoms in the face of the medical therapy, operative treatment was advised.

On admission to Roper Hospital he was a well-developed and fairly well-nourished white male appearing dyspneic. The blood pressure was recorded at 150/30 in the arm. The pulses were "water-hammer" type and a normal sinus rhythm was present. The heart was enlarged to the left. A Grade II systolic and diastolic murmur were present at the aortic area. A Grade II systolic and a low-pitched rumbling diastolic murmur were audible at the apex. The chest was clear to percussion and auscultation, and no peripheral edema was present. Chest films showed moderate cardiomegaly due primarily to enlargement of the left ventricle. An ECG showed changes consistent with left ventricular hypertrophy and delayed IV induction. Wasserman and Kline tests were reported as negative. The final clinical impression was rheumatic heart disease with predominant aortic insufficiency.

Left thoracotomy with insertion of a Hufnagel valve was performed on January 31, 1955. The patient withstood the procedure well, and the post-operative course was uncomplicated except that some retained bronchial secretions necessitated tracheotomy for adequate tracheal toilet. The patient was discharged improved on February 14, 1955.

On follow-up visits to the Heart Clinic the patient no longer complained of orthopnea or dyspnea on exertion although he continued to have angina. There was a slight decrease in heart signs as shown by x-ray.

However, in September, 1956 in spite of digitalis and diuretics, he began to go on a progressive downhill course and died suddenly on November 4, 1956. No autopsy was performed.

Case IV: (Bacterial Endocarditis) A 31 year old white male was admitted to the Medical College Hospital on June 23, 1957. He had a history of having been well until October, 1956 at which time he developed an upper respiratory infection. This was followed by chills and fever, episodes of vertigo, and pains in the left shoulder. He consulted a physician, was treated with antibiotics with only slight improvement and was therefore admitted to the Greenville County General Hospital with the diagnosis of acute bacterial endocarditis. There was no history of rheumatic fever. Treatment was carried out for one month with oxytetracycline and penicillin, and the patient was discharged on restricted activity. In February, 1957 he began to experience episodes of dyspnea on exertion and angina-like pains. Treatment with digitalis and diuretics afforded little relief of symptoms so that the patient was referred to the Medical College Hospital for operative treatment.

He was a well-developed and well-nourished white male appearing mildly dyspneic. Blood pressure in the arms was recorded as 150/46. The pulses were "water-hammer" type, and a regular sinus rhythm was present. The heart was enlarged to the left. A Grade II to III blowing diastolic murmur was audible over the entire precordium. The liver was palpable 6 cm. below the right costal margin. Fluoroscopy and chest films indicated gross cardiomegaly with left ventricular hypertrophy and a first degree heart block. Wasserman and Kline tests were reported as negative. Final clinical impression was aortic insufficiency secondary to acute bacterial endocarditis.

Left thoracotomy with insertion of a Hufnagel valve was performed on July 3, 1957. The patient withstood the operative procedure well, and the post-operative course was uncomplicated.

Since discharge, the patient has had few cardiac symptoms and is able to walk eight blocks without difficulty. There has been a slight decrease in size of the heart as shown by follow-up x-ray examinations.

Summary

A discussion of the etiology and treatment of aortic insufficiency with particular reference to the insertion of a Hufnagel valve is presented. Four illustrative cases of aortic insufficiency due to varying etiology, treated surgically, at the Medical Center Hospitals by insertion of a Hufnagel valve are reported.

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DEFORMITIES OF THE NOSE AND NASAL AIRWAYS

ROBERT F. HAGERTY, M. D. AND MARY L. HAGERTY*
Charleston, S. C.

The nose, because of its uniquely prominent position, is frequently exposed to trauma giving rise to abnormalities of both appearance and function. In general, one can consider the nose as a pyramid supported by the nasal bones superiorly, the lateral cartilages inferiorly, and the alar cartilages at the tip. Along the midline additional support is afforded by the nasal septum which is bony in its superior extent and cartilaginous inferiorly. Very commonly the framework of the nose is injured without destruction of the overlying skin or underlying mucous membrane lining. Such injuries frequently result in hump deformities, depressions of the nasal bridge, and deviations of the nose from the midline usually associated with displacement of the nasal septum and obstruction of one or both of the nasal airways. This frequently gives rise to difficulty in breathing and impaired drainage of the paranasal sinuses characterized by such symptoms as post-nasal drip and headaches.

In order to improve the appearance and functions of the nose, it is necessary to reconstruct or replace the supporting elements of the nasal pyramid and to correct the deviation of the nasal septum. This can usually be accomplished by carrying out a submucous resection and rhinoplasty in one operative procedure through intra-nasal incisions. This combined operation is also effective in making available septal cartilage for correction of any depressions along the nasal bridge. Frequently a sizable segment of the superior septum must be removed with the osteocartilaginous hump and one must be careful to leave sufficient sup-

porting cartilage in the lower half of the nose to avoid a depression. A division of responsibility in this regard, therefore, is usually not desirable.

The success of surgery of this type depends primarily on the analysis of the presenting problem. In addition to a complete history and examination, photographs are taken of both front and profile views, and a facial moulage



Figure 1

A moulage in plaster is made of the face for three-dimensional study (Left). Wax models are poured from the same mould and the nose shaped to the desired form preparatory to surgery (Center). About one year after surgery, the final moulage is made for comparative study and record (Right).

*From the Department of Surgery (Plastic Surgery), Medical College of South Carolina.



Figure 2.—20 year old female

This patient is believed to have suffered a traumatic injury to her nose at age three. In early childhood a prominent hump appeared associated with a progressive difficulty in breathing.

Examination revealed a hump deformity with a full tip. There was a deviation of the septum to the left superiorly and the right inferiorly, markedly encroaching upon the nasal airways.

Submucous resection and rhinoplasty were carried out with removal of the hump, thinning of the tip, and correction of the breathing difficulty.



Figure 3.—29 year old female

During her teens patient noticed difficulty in breathing and the appearance of a hump deformity. A submucous resection was carried out elsewhere with little improvement.

Examination revealed a hump deformity, a low tip, and deviation of the septum to the left severely occluding the nasal airway.

Submucous resection and rhinoplasty were carried out with correction of the hump deformity, elevation of the tip, and removal of the obstruction to the airways.

is made. This moulage is cast in plaster and wax, permitting three dimensional study. The nose is built up with wax or cut down until a shape suitable to the contours of the face is obtained. (Fig. 1) In remodeling the plaster nose, a measuring device can be utilized to compare the results with standard angles for the nasal bridge and columella. It is from these studies together with drawings on the photographs that the desired shape of the nose is determined. All experimentation is thus carried out on the plaster and wax models and on the drawing board. In this manner a concrete goal is established. One has then but to concentrate on duplicating these results on the patient, a formidable enough challenge by itself.

By restoring the plaster or wax model of the

nose to a suitable shape one becomes immediately aware of the deficiencies or excesses of the supporting structures. In the operative procedure these can be reduced or reinforced as the case may be. The degree to which these changes are made depends largely on the taste of the surgeon. We endeavor to secure a straight nasal bridge with a slight upward tilt of the tip, the latter somewhat greater in women than men. Radical changes are avoided, especially the pinched "operated" appearance, the exaggerated tilt to the tip with its overly "cute" result, and the curved or "ski-jump" bridge line.

These patients are operated upon under general endotracheal anesthesia. There is considerable ecchymosis and swelling about the eyes postoperatively, if fracture of the nasal



Figure 4

Examination revealed a rather large nose with a hump deformity and a broad, round tip. The septum almost completely obstructed the left nasal fossa and spurs were present bilaterally.

A submucous resection and rhinoplasty procedure succeeded in reducing the overall size of the nose, removing the hump and thinning the tip together with eliminating her symptoms of nasal obstruction.

← Figure 4.—22 year old female

At age 17 patient was struck on the nose. This was followed by difficulty in breathing and the appearance of a hump deformity.

Examination revealed a rather large nose with a hump deformity of the bridge and a low tip deviated to the right. The septum partially occluded the right nasal fossa, while a spur extended across the floor on the left.

Submucous resection and rhinoplasty were effective in reducing the overall size of the nose, removing the hump, and in thinning and elevating the tip together with replacing it in the midline.

Correction of the septal deviation with its spurs eliminated the breathing problem.



Figure 6.—38 year old male

Traumatic accident of nose occurred ten years previously. A cartilage graft was inserted two years later elsewhere. He had been troubled with smothering sensations and dissatisfied with the appearance of his nose since the accident.

Examination revealed a marked hump deformity with elevation of the nasal tip and columella together with marked deviation of the septum into the right nasal fossa superiorly and into the left fossa inferiorly.

Submucous resection and rhinoplasty were carried out with introduction of an "L" shaped autogenous cartilage graft through a mid-columellar incision. The nasal profile was improved as was the breathing.



Figure 5.—21 year old female

Patient complained of frequent post-nasal drip and sore throat, in addition to the general configuration of her nose.



Figure 7.—21 year old male
Repeated trauma to the nose (football) resulted in

bones is carried out, but this is limited somewhat by a plaster of paris nasal splint and cold compresses. On the fifth postoperative day, the patient is discharged without dressings but with instructions in the use of a nasal splint and is usually able to resume his previous duties within two weeks of the procedure.

A group of cases is presented demonstrating deformities of the nose and nasal airways and their correction by a combined operation of submucous resection and rhinoplasty. The breathing difficulties were alleviated and appearance improved in a single operative procedure except in the final case.

severe difficulty in breathing and in an abnormal appearance. A submucous resection elsewhere corrected the breathing difficulty.

Examination revealed a broad hump of the superior half of the nose with a bulbous depressed lower half. The airways were of excellent patency bilaterally, but the entire profile of the nose was low.

Since septal cartilage was not available to elevate the depression of the bridge, superior segments of the lateral cartilages were rotated superiorly and medially. The entire profile is a little too low and could be improved by a cartilage graft.

The Management of Abruption Placentae. L. L. Hester, Jr., M. D. and J. A. Salley, M. D. (Charleston) Am. J. Obst. 74:1218, Dec. 1957.

There is considerable difference of opinion concerning the role of cesarean section in the management of abruption placentae. The incidence varies between 3% for service patients at Roper Hospital to 51.6% elsewhere. In this series of 100 cases, three had cesarean sections, two of which were performed on patients with previous sections. Therefore, only one was done for abruption placentae alone. Cesarean section is indicated for fetal distress, uncontrolled hemorrhage, and the usual obstetrical indications. In short, classification is:

- Grade 0. These are clinically unrecognized before delivery. (Diagnosis is based upon examination of placenta).
- Grade 1. These show external bleeding only, or mild uterine tetany, but no evidence of maternal shock.
- Grade 2. In this group there is uterine tetany, ordinarily with uterine tenderness, possibly external bleeding, fetal distress (or death), but no evidence of maternal

shock.

- Grade 3. Here there is evidence of maternal shock or coagulation defect, uterine tetany, and intrauterine death of fetus.

If clinically and on sterile pelvic examination abruption placentae is diagnosed, the treatment for each grade of severity is briefly as follows:

- Grade 1. Bedrest and observation except in a patient with a near or at term fetus and a ripe cervix; then amniotomy is indicated. Blood replacement only if bleeding is excessive.
- Grades 2 and 3. Oxygen, blood replacements, amniotomy, and in certain selected cases a Pitocin infusion. Fibrinogen is made available. Cesarean section for fetal salvage in Grade 2.

Fetal mortality was 68% (50% had no fetal heart tones on admission). Prematurity 51% in Grade 1, 72% in Grade 2, and 46% in Grade 3.

Maternal complications were postpartum hemorrhage 12%, endometritis 9%, hypofibrinogenemia 3%, renal failure 3% and maternal death 4%.

MANAGEMENT OF IMPERFORATE ANUS

R. RANDOLPH BRADHAM, M. D.

Imperforate Anus is a broad term which includes multiple types of obstructive malformations of the terminal bowel. These are frequently associated with anomalies of the genito-urinary tract. The incidence of imperforate anus is approximately one per five thousand births. Recent advances in treatment have improved results and lessened the morbidity and mortality.

The separation of the cloaca, a terminal cavity common to the urogenital sinus and posterior intestinal tract, into cavities which form the rectum and anus and the lower urinary tract occurs between the 5th and 7th week of embryonal development. Arrest in development results in imperforate anus with and without an associated fistula.

Classification

The most commonly used classification is that of Ladd and Gross¹ which is as follows:

- | | |
|----------|--|
| Type I | Incomplete rupture of the anal membrane or stenosis at a point 1-4 cm. above the anus. |
| Type II | Imperforate anus due to persistent membrane. |
| Type III | Imperforate anus but with rectal pouch separated from the anal membrane and terminating blindly either within or above the pelvis. |
| Type IV | Normal anus with rectal pouch ending blindly. The anal and rectal pouches are sometimes separated only by a membrane. |

Fistulas and Associated Anomalies

A fistula may occur with any type but is much more common with Type III. One hundred and thirty cases were recently reviewed by the author and in eighty-three (64%) an associated fistula was present. Seventy-four of these were in Type III cases. The three types of fistulas occurring in males are recto-urethral, recto-vesical, and recto-perineal. In the female, recto-perineal, recto-vaginal, and recto-vesical occur, although the last named is a very rare finding.

Many of these infants have other congenital

anomalies which add perceptibly to the morbidity and overall mortality. Nine of the 130 cases reviewed had severe congenital heart defects and eight had a tracheo-esophageal fistula. Forty-eight per cent had at least one anomaly exclusive of the imperforate anus. One infant had ten anomalies.

Diagnosis

The Type II and III anomalies should be discovered immediately by routine new-born examination. Discovery of Type I anomalies depends upon the degree of stenosis present and for that reason they are noticed at varying periods of time following birth. Difficulty in defecation, passage of ribbon like stools, and abdominal distention may lead to this diagnosis. Unfortunately diagnosis of Type IV malformations is often delayed by the presence of a normal anus. Signs of intestinal obstruction may be the first indication that this type exists.

Passage of meconium or air through the vagina or urethra, or through abnormal perineal openings is evidence of the presence of a fistula and suggests the location. In a male child, the urine should always be examined for meconium and when the Type III anomaly is present, a recto-urinary tract fistula should be strongly suspected and searched for. Probing or injecting external openings with contrast media aid in determining the level of the rectal pouch.

Roentgenograms taken in the inverted position as described by Wangenstein and Rice² are helpful in determining the termination of the bowel. One must consider, however, that it might be 24 hours before the gas would traverse the bowel. Therefore, roentgenograms before 24 hours might not be accurate. Curtis and Kredel³ reported gas reaching the terminal bowel by 15 hours. Massage of the abdomen was used by Lee⁴ to help the gas reach the terminal bowel more quickly. Tenacious meconium in the terminal bowel may also prevent the gas from reaching the end of the rectal pouch. Other important methods are in-

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jection of opaque media into fistulas and distal colostomy segments, cystography, and urethrograms.

Treatment

The majority of the Type I anomalies are treated satisfactorily by repeated dilatations. Cruciate incisions are required to perforate the thin diaphragm in Type II. A strong word of caution must be injected here against the blind "stab" procedure that has been done so many times with the hope that this would open up an adequate anal passage. This does nothing but wreck the small perineum and cause serious damage to the urethra and important pelvic nerves. There is absolutely no place for this procedure in the treatment of imperforate anus. Where a thin membrane exists the dark meconium can be seen to cause a bulge in the anal area. This should be gently incised or excised but never "stabbed".

Type III cases require a very careful evaluation pre-operatively and a definite plan of treatment before operation is begun. Emphasis must be placed on the determination of the distance of the blind end of the rectum from the skin, and the presence of associated anomalies and fistulas. It is not necessary that operation be carried out in the first few hours of life but a full 24 hours may be used to evaluate the patient.

Repair can be done satisfactorily through a perineal approach if the blind end of the rectum is 1.5 cm. or less from the anal skin. A urethral catheter should always be inserted pre-operatively to aid in identification of the urethra so that damage to it can be avoided. A longitudinal incision is made over the anal dimple. The anal sphincter is transected in the midline and the terminal rectum identified, mobilized, and sutured to the skin without tension. If there is an associated low-lying recto-perineal or recto-vaginal fistula, the fistula can be mobilized and brought out through the anal incision. Definitive correction is sometimes delayed if the fistula is large and adequate for evacuation.

In 1948, Rhoads, Piper, and Randall⁵ described a one-stage abdomino-perineal operation for cases not suitable for correction by the perineal approach alone. This procedure has been used widely and effectively and has

done much to improve the operative results on certain of the Type III and IV anomalies. It has been used to greatest advantage in the (a) Type IV cases, (b) the Type III cases with a rectal pouch above 1.5 cm., and (c) all Type III cases with a recto-urethral or rectovesical fistula and with high-lying recto-vaginal and recto-perineal fistulas. The operative details are well described by Rhoads et al,⁵ Potts,⁶ Kiesewetter,⁷ and Gross.⁸ The advantages of this procedure are:

1. Repair of imperforate anus and resection of associated fistulas is accomplished in one stage.
2. Recurrence rate of recto-urinary fistulas is greatly reduced.
3. The anal sphincter is dilated and preserved.

Damage to pelvic nerves followed by neuromuscular weakness is a possible disadvantage.

Transverse colostomy is indicated in infants weighing less than 6 pounds, in those with some other severe anomaly, and in those appearing in poor condition at birth. Definitive correction can be made when the child is older and is a better operative risk. Mayo and Rice⁹ advocate careful technique and separation of the two barrels of the colostomy well enough to avoid distal loop trouble such as impacted feces, barium concretion, prolapse, or retraction.

Results of Treatment

Results of treatment will be directly proportional to the accuracy of the pre-operative evaluation, plan and choice of procedure, careful technique, and post-operative care and follow-up. Blind probing of the perineum, perineal dissections without first locating as accurately as possible the rectal pouch, and attempts to suture an inadequately mobilized rectum to the perineal skin will all result in unnecessary scarring. Scar formation in the perineum makes future correction most difficult and establishment of normal bowel function almost impossible.

Case 1. J. B. was a 7 year old white male child first seen in May, 1957. There was a history of imperforate anus at birth with establishment of a passageway through a perineal operation. At 6 months of age it was noted that feces and gas were passed through the urethra. The parents were advised that operative correction was necessary but this they refused. Since

then the urethra had become obstructed with fecaliths and all urine and feces were passed per rectum.

The patient was a pale child who appeared somewhat retarded physically. There was a moderate stricture of the anus. There were fecaliths in the penile urethra, the largest measuring 3 cm. in diameter. A low recto-urethral fistula was demonstrated roentgenographically. Because the fistula was just below the skin, it was resected through a perineal approach. A supra-pubic cystostomy, ano-plasty, and removal of urethral calculi were done at the same time. It was necessary post-operatively to do a transverse colostomy because of infection in the perineal wound. This has been closed subsequently.

This child now has good bowel control, fair urinary control and has begun school for the first time. Because of the low-lying location of the fistula it is believed that it probably resulted from damage to the urethra at the time of the original operation. Had it existed at birth, it could have been removed by utilizing the abdomino-perineal approach. This approach would have allowed normal bowel wall to be brought down by the urethral stump of the fistula, thus making recurrence more unlikely.

Careful follow-up and constant surveillance until the child reaches adolescence is necessary in order to obviate many of the evacuation problems that these children might encounter. This was well demonstrated in the following case.

Case 2. J. P. was a 10 year old colored female who was noted to have a protuberant abdomen when she was seen in the heart clinic for a sinus arrhythmia. History revealed that she had had correction of imperforate anus at birth. At the age of 6 years a recto-vaginal fistula was repaired. During the year prior to her visit here she had had difficulty with evacuation and soiled her clothes frequently. She presented protuberant abdomen with a large colon containing much feces. A rectal stricture was found and a diagnosis of acquired megacolon was made. She was admitted to the hospital and it required 2 weeks to evacuate the colon with enemas, a liquid diet, and oral dioctyl sodium sulfosuccinate (Colace). Anal dilatation was done twice a day. At the time of discharge the colon was completely evacuated and the anal stricture much improved.

The mother was instructed in daily dilatations, daily enemas to be progressively decreased in frequency, cathartics as needed, and a diet rich in hydroscopic agents which would make the stools softer and easier to pass. A public health nurse was instructed in this program and was to visit the child at regular intervals. Periodic follow up clinic visits were arranged. On this definite type of program, the child has done well, having normal bowel movements with no soiling of her clothes. No more fecal impactions have occurred. This result brings out the value of close follow up in these children.

Case 3. C. L. is a 2 year 9 months old white male

child born with an imperforate anus and recto-urethral fistula. There were numerous congenital malformations of the ribs and vertebrae as well as bilateral inguinal herniae, club foot, and congenital dislocated hip. Proper diagnostic methods were utilized and repair of the imperforate anus and resection of the recto-urethral fistula were done. The surgeon elected the perineal approach because the blind end of the rectum and fistula was only 1 cm. above the anal skin. A good result was obtained although there was some retraction of the rectum.

This child had excellent post-operative follow-up by the doctors and parents. The parents were very conscientious in dilating the anus and avoiding constipation which might lead to fecal impactions. Recent examination revealed a soft, pliable anal orifice with no evidence of stricture or acquired megacolon. Sphincter tone is poor but it is hoped that the child will be able to utilize the gluteal and levator ani muscles for bowel control. This case well demonstrates the good result that can be obtained when proper treatment is instituted and continued.

Conclusions

It must be concluded that inadequate initial treatment will give poor results. Imperforate anus is associated with a high incidence of fistulas and other anomalies and careful pre-operative evaluation must be done to detect the presence of these and to determine the distance of the blind end of the rectum from the anal skin. A definite plan must be formulated before operation is begun and the abdomino-perineal approach should be selected in certain cases. Transverse colostomy has its place in infants weighing less than 6 pounds, in those showing evidence of other anomalies, and in those appearing in poor condition at birth. A careful follow up until the child reaches puberty will avoid many unpleasant sequelae.

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THE INSURANCE INDUSTRY'S ROLE IN SERVING THE HEALTH CARE FIELD

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Health care of the American people involves prevention, diagnosis and treatment of sickness and the rehabilitation of the patient. The insurance industry makes no attempt to sell medical care, or to control those who provide such care. It is a mechanism by which people can buy protection against an unforeseeable cost which might occur at an inconvenient time. This type of coverage is referred to as indemnity insurance, in that it provides compensation for a loss. It works best when it neither encourages nor discourages care as given by hospitals and physicians. By confining its activities to the payment of indemnities after service has been rendered the insurance industry abstains from any attempt to interfere with the free choice by the patient in choosing his physician or his hospital.

The insurance mechanism has certain fundamental principles. Insurance works best when it covers an infrequent large loss as opposed to frequent small losses. The cost of handling the frequent small losses becomes disproportionate. A hazard to be insured against should be an unexpected and undesirable one, the occurrence of which should be beyond the control of the person insured. Illness, to a certain extent, is subjective. People do not seek medical care to the same degree. Health insurance, therefore, does not entirely meet these fundamental requirements and principles. Within the bounds of these limitations, health insurance is subject to abuse and over-use. The insurance policies define certain limits within which benefits are determined and pay-

able. It is the medical profession that has, to a major extent, controlled the degree of success the voluntary plans have had. The avoidance of compulsory insurance, with medical care under governmental control, depends on continued cooperation of physicians, and on the insurance companies' ingenuity in devising plans considered reasonable by both physicians and the public. It is in this endeavor that the industry welcomes opportunities such as this to discuss what we think is a mutual problem.

Growth of Health Insurance

There has been a spectacular rise in hospital, surgical and medical expense protection during the past fifteen years. Since 1940 the number of persons with hospital expense protection has increased from 12 million to 115 million. The other health insurance forms have grown in similar fashion, surgical expense protection from 5 million to 101 million and medical expense coverage from 3 million to 64 million at the end of 1956.

Hospital expense coverage written by insurance companies represented 53 per cent of the total, Blue Cross 43 per cent and independent plans the remaining 4 per cent. These independent plans include industry sponsored health care, college health plans and plans offered by group clinics.

There was a total of 63 million persons with insurance company surgical expense protection at the end of 1956. This figure was 57 per cent of the total.

Blue Shield led the field in regular medical expense protection, accounting for 49 per cent of the total, with insurance companies providing 43 per cent.

The type of insurance we refer to as major

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medical expense insurance is designed to reduce the impact of the great costs of serious or prolonged illness. Generally speaking, these plans are broad in scope and cover a wide range of expense, regardless of whether they are incurred in the hospital, the physician's office or in the home. At the present time, this is the fastest growing type of insurance. Beginning in 1950, this type of insurance probably covers over 10 million persons at the present time.

The oldest form of health insurance is that against loss of income due to sickness and accidents. This insurance is intended only for the income producer to provide him with funds when his earning power is cut off due to disability. There were approximately 30 million wage earners with this type of protection covered by insurance companies.

Another measure of the role of insurance companies in paying for the cost of medical care is the amount of benefits paid. \$3,640,000,000 was paid by insurance organizations in 1956. Of this, over 2 billion was paid in claims by insurance companies.

Aside from the types of insurance already mentioned, other forms of insurance contribute toward paying the cost of medical care. The proceeds of life insurance often pay the expenses of a person's last illness. Some 5 million persons carry personal accident insurance, 40 million workers are covered by Workmen's Compensation, but we cannot include this in the voluntary column, as it is required by law. Personal liability insurance benefits help pay the cost of some accidents.

Evolution of Health Insurance

The history of health insurance is a long one. Forerunners of this type of insurance began over 100 years ago. Insurance against accidental injuries occurring in travel was written about 1850. In 1890 companies began insuring against sickness as well as accidental injuries. Insurance against the cost of hospital care had its beginnings in the early 1900s, but did not become popular until the depression beginning in 1929. Development at this time was greatly stimulated by the Blue Cross movement. During the depression, hospital, like physicians', collections were at a low ebb. This movement did much to improve the sta-

tus of the hospitals. Insurance companies until this time gave more emphasis to policies covering loss of income rather than insurance against the cost of medical care. It was during the thirties and forties that insurance companies insured large numbers of persons against hospital expense by adding this feature to existing group life and disability insurance. Through this mechanism insurance companies made their greatest contribution in spreading health insurance.

Since World War II there has been marked growth in individually sold health insurance. This has helped to cover a segment of the population not readily enrolled by the group mechanism. It has been an accomplishment of the American agency system. Millions of persons would not have health insurance coverage if it were not for the sales effort of this agency system.

Problems of Individual Insurance

Individual insurance, however, presents many problems that group insurance does not encounter. The marketing cost is necessarily higher. The problem of selection is an important one. If there were no selection a person would be inclined to postpone buying a policy until the need for hospitalization or for medical care was imminent. A nominal frequency of what we call "anti-selection" can throw out of balance the relationship between premium income and claim payments. This process is not necessarily fraudulent. Many applicants are quite naive about it. Sometimes an applicant is asked why he wishes to buy a hospital policy and he will reply, quite frankly, that he has been advised to have an operation. Individual policies have provisions eliminating payment for pre-existing disease, waiting periods before payment for maternity benefits and sometimes riders waiving payment of claims for certain existing defects.

Administration of claims involving these restrictions is based on written proofs completed by physicians. Insurance companies are in a position to know that the attending physicians call the signals in the health insurance game. The success that this voluntary insurance enterprise has had is due to the cooperation of the medical profession. Often this responsibility has been a burden and carried out in spite

of pressures from the patient—the policy-owner—to present the claim in a slanted fashion. It is under these circumstances that the physician may compare health insurance to the young high school student working a problem in chemistry laboratory, mixing solutions, spilling it over the counter, his apron and the floor. The instructor on viewing the situation says, “Son, are you a part of the solution or a part of the problem?”

These pressures are sometimes quite ingenious. In order to remove maternity restrictions the suggestion may be made that a mole be removed during the hospital stay and that such be considered the reason for the admission. There is the case where an appendix is removed during a cesarean and the operation listed as an appendectomy. Claim has been made for a cystocele operation under a policy that did not cover disorders of the female genital tract. Argument was presented that this was a bladder operation.

Problems of Insurance

Of more concern to the insurance industry are the problems of a broader nature, criticisms that fall under the following headings—

1. Burden of paper work too great.
2. Hospitals are unable to establish extent of benefits at time of admission for credit purposes.
3. Encouragement of unnecessary hospitalization.
4. Too much emphasis on small claims that entail high overhead.
5. Insufficient protection against catastrophic expense.
6. Surgical fee schedules—unrealistic or inequitable.

These are by no means all of the problems but they are typical and may be used as a basis of discussion. What can and what is the industry doing?

In 1946 there were conferences between the American Medical Association and representatives of the industry to discuss proposals for compulsory federal health insurance. It was apparent that there was no accurate information available regarding the extent of voluntary insurance against the cost of illness. It was at this time that the Health Insurance Council was formed. One of its primary accomplish-

ments has been the completion, publication and distribution of an annual survey of the Extent of Voluntary Health Insurance Coverage in the United States. The survey has been used extensively in subsequent Congressional hearings. This Council also concerned itself with the formation of Hospital Admission Plans; the purpose being to certify hospital payments at time of admission rather than at the time a claim was presented after discharge. It began the long arduous task of devising uniform claim forms satisfactory to the hospitals, the medical profession, and some 800 companies. During the past 10 years it has concerned itself with certain technical aspects of the business such as the payment for blood used in blood transfusions, the relationship between hospitals and physicians with regard to the payment for the services of radiologists, pathologists, and anaesthesiologists, the nomenclature used in surgical schedules, insuring those in the older age group, insuring the substandard risk, covering the cost of dentistry, etc.

Major Medical Insurance

It fell to the lot of the actuaries of a few of our large companies to devise a plan that would attempt to solve some of the other problems. They developed the type of insurance referred to as major medical or comprehensive medical insurance. Such coverage may be divided into two sub-classes. The most popular at present is a supplemental plan which is imposed on top of existing basic hospital and surgical insurance. This type has a rather high deductible—around \$500. The other is referred to as basic major medical or comprehensive medical insurance. This is designed to replace basic health insurance but uses a low deductible—in the range of \$50 to \$100. Both of these plans cover medical care in the home or office. This eliminates the pressure for hospitalization. There is no fee schedule. Provision is made for the payment of reasonable or usual charges. These plans can have high ceilings, in the neighborhood of \$10,000, to cover catastrophic costs. There is also a co-insurance feature requiring the patient to pay a percentage, usually 20% or 25%, of the bill over the deductible. This is an attempt to retain some customer responsibility and forestall unreason-

able demands for service.

The lack of a fee scale places great confidence in the medical profession to charge the usual fee, in spite of the existence of the insurance. The surgical scales in the traditional types of surgical insurance have been a source of irritation to the profession and understandably so. Although scales have been designed at times to cover only a portion of the surgeon's usual fee, some patients have assumed that the payments should cover the whole fee. It has been difficult to maintain a proper relative value between the fees for the operations in the various surgical specialties. The method used by major medical in eliminating the fee schedules should solve some of the problems but many students of the subject, including many members of the medical profession, point out that this method could have an inflationary effect on medical charges. If it does, this type of insurance could become too expensive to be saleable. It is largely because of this possibility that the president of the American Medical Association has urged the industry to explain the mechanism of this insurance to state and local medical groups. The Health Insurance Council has organized state committees to work with hospitals and medical groups to find ways of making health insurance work on a voluntary basis.

Healthy Competition

It has been stated that the Health Insurance Council has the purpose of supplanting Blue Cross and Blue Shield. A few weeks ago I had lunch with an outstanding actuary who is now president of the Health Insurance Association of America. We were discussing the future of health insurance. He remarked that the industry had great stake in the success of Blue Cross. If the 50 million persons now covered by Blue Cross should lose their benefits, the insurance industry could not possibly sell them insurance before there would be a public demand for the government to step in. The reverse is also true. Most group insurance is intimately inter-woven with disability and retirement pensions by union negotiations and it would be a tedious and complicated task to rewrite it, using a standardized plan.

There is, at the present time, active and

healthy competition between the insurance companies, as well as between the insurance industry and the Blue Cross. Some people are impressed by the distinction between profit and non-profit plans. The largest insurance companies are the mutual companies. These companies strive to operate at a profit, but the profit accrues to the policyowner. Stock companies operate on capital subscribed to by stockholders, who share the risk and the profit. I don't believe the citizens of either your state or my state are ready to say that the capitalistic system is all wrong. One's reaction will often depend on the way a case is presented. Effective communication can be a tricky process.

It is somewhat like the fellow who came home and told his wife, "My dear, when I look into your face, time stands still." He communicated very successfully.

The other fellow who came home and tried to communicate the same idea, said "My dear, your face would stop a clock." He didn't get his idea across.

The one idea we want to convey is that there should be a common interest between the medical profession, the Blue Cross, and the insurance industry. It is the preservation of the voluntary way, with free choice by the individual. If we can solve minor technical difficulties, I believe we can work together to reach the greater ultimate goal.

If we cannot, we may continue to see the trend toward lay-directed medical care, union-operated plans, and further extension of government-sponsored medical care.

Final Note

There is just one more criticism of health insurance that I would like to mention, and concerning this one, we are definitely not on the defensive. This is the implication that insurance does not control or contribute to the quality of medical care. The insurance industry emphatically adopts the position that it is not qualified and has no mission to control the quality of medical care. This is the prerogative of the medical schools, state licensing boards, and medicine itself, as represented by societies such as this. May it remain in these good hands.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

RIGHT BUNDLE BRANCH BLOCK

(and Posterolateral Myocardial Infarction)

DALE GROOM, M. D.
Dept. of Medicine

Case Record—During the week prior to his admission to the hospital a 57 year old civil engineer experienced an attack of dizziness and headache with impairment of sensation in the left upper extremity, followed several days later by an episode of substernal pain. The latter symptoms had come on at night following a large meal, had persisted for several hours, and recurred the next morning. The patient could recall no similar symptoms in the past although he acknowledged a family history of coronary and cerebral vascular disease with premature death.

Because of continued chest pain an electrocardiogram was made which revealed right bundle branch block with depression of S-T segments in some precordial leads and other indications of acute myocardial infarction. Corroborative evidence of this diagnosis was obtained in elevated values of the patient's serum transaminase, white blood cell count and sedimentation rate, together with the low grade fever and a transient pericardial friction rub observed during his hospital stay.

An electrocardiogram recorded on a routine re-examination of the patient six months later showed the same conduction abnormality. Except for some T wave changes in the direction of normal it was unchanged from the one illustrated here, made seven days after the onset of his chest pain.

Electrocardiogram—The most obvious abnormality is a widening of the QRS complexes to 0.12 sec. They are variously slurred or notched in most leads, being entirely upright deflections in V-1 and having R waves of markedly decreased amplitude in V-6. Deep Q waves having a width of about 0.04 sec. are present in leads III and aVf. The T waves are small or isoelectric in leads from the extremities but are symmetrically inverted in V-5 and V-6.

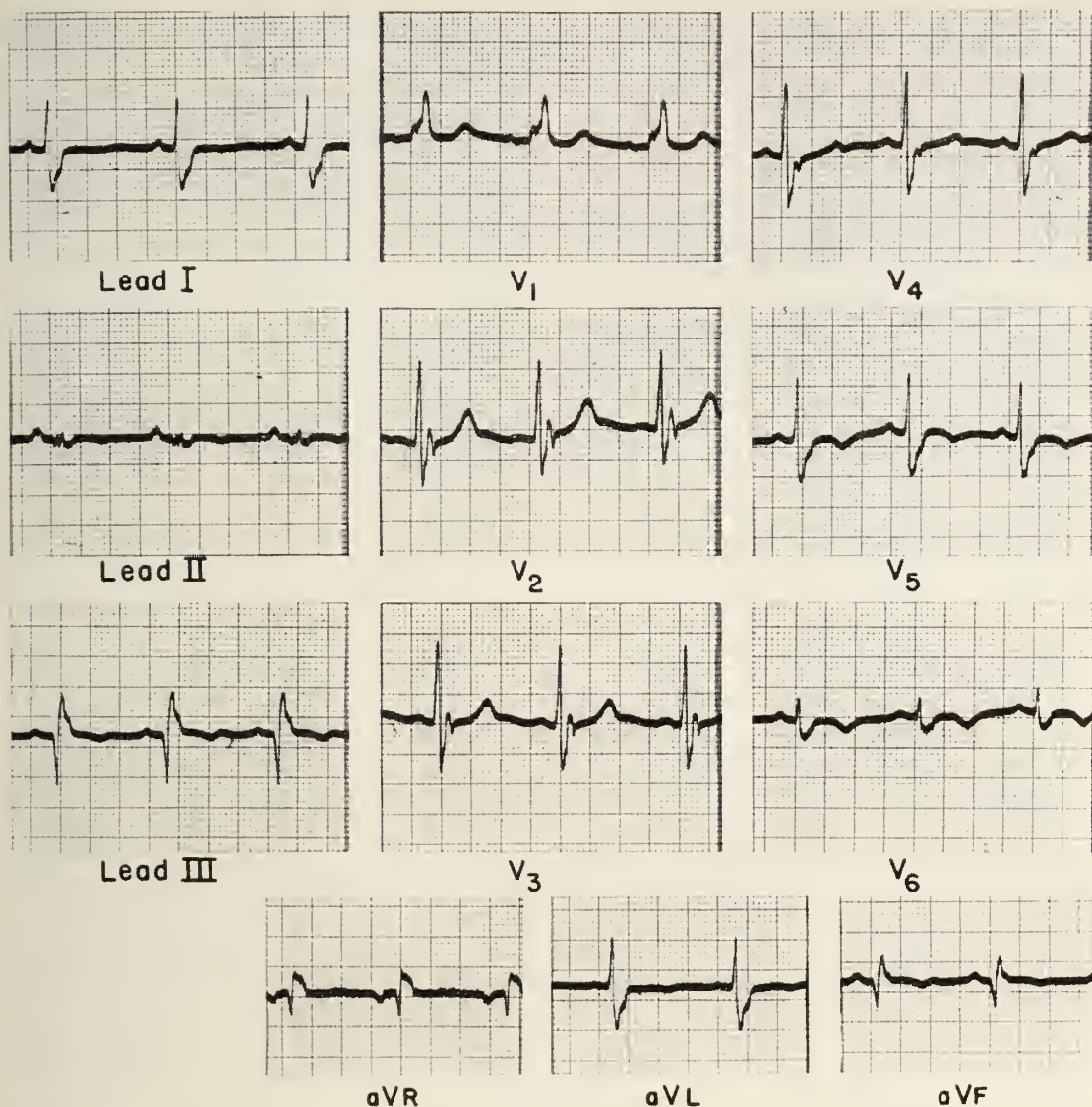
Normal P waves throughout with P-R intervals of 0.16 signify a normal sinus rhythm.

Discussion—Transmission of the excitation impulse from the A-V node to the ventricular musculature is normally accomplished by means of the bundle of His, its branches, and their ramifications. These tiny

bands of conduction tissue, having rates of transmission far in excess of those of ordinary myocardial tissue, bifurcate below the A-V node into the right and left bundle branches which traverse the interventricular septum on the two sides and end in arborizations in the subendocardial layers of the outer walls of the right and left ventricles. Along the way the left bundle gives off a small branch to the interventricular septum itself so that this area of ventricular musculature is normally activated first, in a direction from left to right through the septum, accounting for the familiar Q waves of septal activation normally seen in leads from the left side of the heart.

Anywhere along these conduction pathways transmission of the impulse may be delayed or blocked completely because of either some disturbance in physiology of the conduction tissue or, more commonly perhaps, a pathologic abnormality of structure. A block occurring in one of the main bundle branches is designated as right or left bundle branch block according to which side is blocked, while one located in a terminal branch is commonly referred to as an arborization block. Usually a block in one of the bundles is complete and permanent; occasionally it may be intermittent, affecting some beats and not others, or occurring only at certain times. Or transmission of the impulse may be only slowed down or delayed in one of the bundles, in which case incomplete bundle branch block is said to exist. In any event, the excitation wave ultimately reaches and spreads out through the walls of both ventricles evoking a mechanical contraction which is not appreciably impaired by the circuitous route the impulse may have followed to get there. Hence bundle branch block is entirely an electrocardiographic diagnosis.

The two main criteria for diagnosis of right bundle branch block are: widening of the QRS complexes (to 0.12 sec. or more for complete block, or 0.10 to 0.12 for incomplete block according to accepted standards), and a delay in activation of the right ventricle. Other changes do occur which are characteristic and helpful in identification of the conduction abnormality but these are the *sine que non* for the diagnosis. The ventricular complexes (customarily referred to as QRS although of course they need not necessarily be composed of Q, R, and S waves in any given lead) are widened because the impulse must take a circuitous route around the block in the right bundle branch, either going down the opposite normal bundle and activating the left ventricle first and then spreading back to stimulate the right ventricle as has been popularly believed, or perhaps escaping from the blocked bundle altogether and coursing through the



myocardial tissue itself at its slower rate of transmission as some studies have suggested. In either event, instead of the virtually simultaneous stimulation of both ventricles which normally requires no more than 0.08 or 0.10 sec. a delay is imposed on the right side and the total time required for ventricular depolarization is prolonged, sometimes reaching as much as 0.18 sec. The same delay is displayed more specifically in leads from the right side of the heart where the intrinsicoid deflection denoting activation of the right ventricle occurs later in the cycle. Here it is seen best in V-I (although in some cases special leads such as V₃R must be taken further to the right to observe this, depending on individual differences in position of the heart) which shows an interval of 0.10 sec. between onset of the QRS and peak of the

tall R prime wave, as against a normal activation time which ranges from 0.015-0.035 sec. In right bundle branch block this interval is .06 sec. or more.

Other abnormalities occur in the QRS complexes when the right bundle is blocked. A lead such as V-I or V₃R generally shows an initial R wave due to normal activation of the interventricular septum, followed by a downward S wave which may be only a small notch and coincides with the spread of the stimulus to the left ventricle, followed by a second and unusually tall R wave designated as R prime. Its amplitude is increased because it represents depolarization of the right ventricle which occurs later than normal and is consequently unopposed by the usual concurrent forces of opposite direction in the left ventricle. The same potential appears with opposite polar-

ity as wide-slurred S waves in leads such as V-6 and aV1 from the left side of the heart. But here the intrinsicoid deflection occurs at a normal time because the left ventricle is being activated in a normal manner.

Bundle branch block also produces secondary alterations in the S-T and T wave components. It is important to note that these abnormalities which can be rather conspicuous at times are secondary to aberrations in the process of depolarization and hence do not in themselves imply any derangement in the physiology of the myocardium. The devious and prolonged course of depolarization inevitably alters the pattern of repolarization in the ventricles, perhaps allowing the latter to begin in some areas before the former is completed causing the S-T segments to appear displaced above or below the baseline. Unless infarction or some other active disease of the myocardium is also present, this displacement, if evident at all, is usually a downward one and the T waves are inverted in leads over the side of the heart which is blocked. As a matter of fact, bundle branch block tends to reverse the T waves in all leads so that they are in a direction opposite to the main deflection (i.e., the widest deflection) of the QRS complexes. That such is not the case in this patient's tracing, showing T waves which are upright over the right precordium and inverted over the left, suggests that the conduction abnormality is probably accompanied by some disease involving the myocardium as well.

In making the diagnosis of any type of bundle branch block one must always observe carefully the P waves and P-R intervals to determine that conduction above the ventricular level is normal or that the impulse is actually reaching the A-V node or is arising no lower than the bifurcation of the His bundle. Should the pacemaker be located in one of the ventricles as it is in an idioventricular rhythm the ventricular complexes will closely resemble those of bundle branch block because the route of transmission at this level is similarly aberrant. On the other hand, impulses from a pacemaker situated in the A-V node or above, whether the atrial rhythm is normal or not, will be transmitted down the bundle of His and its branches thereby revealing any block in this conduction system.

Myocardial infarction can usually be suspected or diagnosed with considerable certainty in the presence of *right* bundle branch block, probably because nearly all infarctions involve primarily the left ventricle and stimulation of this area of the heart through the intact left bundle remains unimpaired. Infarction of the

anterior wall is manifested by diminution or loss of R waves in precordial leads, while one involving the septum may result in disappearance of the small R wave of septal depolarization. Posterior (including diaphragmatic) infarction is usually best displayed in leads III and aVf, and lateral wall involvement in leads such as V-6, 7 or 8 recorded from the left lateral wall—both evident in this patient's tracing. The S-T and T wave abnormalities produced in the acute stage of infarction must be evaluated with consideration of what the defect in conduction does to these segments of the electrocardiogram.

Bundle branch block itself may be a manifestation of infarction, as it probably was in this patient. As such it is more commonly associated with posterior than anterior infarcts because most of the blood supply to the A-V node, the bundle of His and its branches, is derived from the posterior (right) coronary artery.

The differentiation of right bundle branch block from right ventricular hypertrophy by means of the routine 12 lead electrocardiogram can be difficult at times. In this the technique of vectocardiography has been demonstrated to be of real clinical usefulness. Several generalizations, however, facilitate this differential diagnosis in conventional tracings. Ordinarily the QRS interval is less than 0.12 sec. and there is less delay in depolarization of the right ventricle (only about 0.03-0.05 sec.) when hypertrophy alone is present. Also in this condition a lead such as V-1 over the right ventricle will usually show a QR complex or a simple upright R wave rather than the notched or R, S, R prime deflections which are characteristic of right bundle branch block. A very tall R prime wave here, on the order of 15 mm. or more, suggests both hypertrophy of the right ventricle and right bundle branch block. But recourse to the patient's clinical findings may provide the most conclusive answer.

Right bundle branch block is a relatively common electrocardiographic abnormality and is generally considered to be of less ominous significance than left bundle branch block. Transitory forms of it are sometimes seen in acute myocarditis, in pulmonary embolism or any condition which places unusual stress on the right ventricle, as well as in coronary disease. Occasionally it is seen in ostensibly normal hearts where it may represent a congenital anomaly of conduction. A permanent block can result from a lesion of minute size which escapes detection at autopsy examination. Like most conduction defects, bundle branch block is a non-specific abnormality but one which almost always denotes organic heart disease.





PATHOLOGICAL CONFERENCE

HISTORY: This 13 year old colored girl was admitted to the hospital from the clinic with a history of intermittent episodes of peri-umbilical pain, nausea and vomiting of approximately four months duration. She was also found to be anemic. Treatment in the clinic with Dramamine, had resulted in cessation of vomiting and improvement in the pain. She was admitted to the hospital for a comprehensive workup. The physical examination was essentially negative except for pale mucous membranes. Laboratory studies revealed that the patient had a hypochromic microcytic anemia, normal gastric acidity, slight erythroid hyperplasia of the bone marrow and the following types of hemoglobin by electrophoretic determination: Hbg. S-11%, Hbg. A-89%, Hbg. F-0.71% (Alkali denaturation). Two examinations of the upper gastrointestinal tract by x-ray revealed hypertrophic rugal folds. Sigmoidoscopic examination was negative as were barium enemas. The urine was negative for porphyrins. On the 14th day of iron therapy the hemoglobin was 7 gm. with a reticulocyte count of 3.7. The hemoglobin determinations on admission were in the vicinity of 4.5 gm. with 2.8% stippled erythrocytes. Lung fields were clear on x-ray examination and no abnormalities were noted except for bilateral cervical ribs and sacralization of the transverse process of L-5. Tuberculin test (PPD first strength) was negative at 24, 48 and 72 hours. After an 18 day hospital stay the patient was discharged on an ulcer type regimen with a final diagnosis of hypochromic anemia and hypermotility and congestion of stomach.

She was again admitted to the hospital two months later. She had done well for two weeks following discharge but then began having headaches, generalized migratory muscular pains, nausea, vomiting, anorexia, low grade fever, generalized weakness and malaise. She had been seen about one week previous to this admission in the emergency room and found to be lethargic, emaciated and extremely pale. A left inguinal lymphadenopathy was noted as well as questionable cardiomegaly. On rectal examination a hard tender 1-2 cm. nodule was found attached to

the uterus in the left lower quadrant. She was seen subsequently in the Gynecology Clinic and a firm 3 x 3 cm. mass was palpated in the posterior cul de sac. Culdoscopy was unsuccessful.

On admission she had fever of 101° F. and she was poorly nourished and in acute and severe distress. Her skin had poor turgor. There was limited expansion of the chest and the respirations were rapid and shallow and labored at 72 per minute. Breath sounds were decreased and coarse with some dullness over both bases and questionable rales. The heart did not appear enlarged and there was a strong PMI in the 5th left intercostal space within the mid-clavicular line. Rate - 136, BP 120/64. Grade I systolic murmur. The abdomen was soft and flat. The liver was down 5 cm. and tender. Active peristalsis was detected. A 3 x 3 cm. firm movable mass was present in the left lower quadrant of the pelvis. A 3 x 3 cm. firm tender movable mass was noted in the posterior cul de sac.

Laboratory Data: Urine-yellow, acid, Sp. Gr. 1.018, Alb. 0, Sugar 0, Acetone 0, WBC 2-3, RBC 0, CBC-Hbg. 5.5, RBC 2.95, WBC 23,000, Lymphs 29, Monos 1, Polys 70, Non fil (7). VPC 21, Retic. 1.2 Stool-occult blood +++++. BUN 17 mg per 100 ml., Blood sugar 118 mg. CO₂ 60. Coombs negative. L. E. Prep. Negative. Blood culture—Negative. Negative tuberculin.—O. T. 1:1000, Negative at 24, 48 and 72 hours. O. T. 1:100—Negative at 24 hours.

Course: The patient was given digitalis, placed in oxygen and given massive antibiotic therapy. On the second hospital day she was given a 500 ml. transfusion of whole blood. Repeat chest films one week after admission showed much more lung infiltration than had been present on admission. There was little or no improvement at any time and on the seventh day the patient began having increasing respiratory difficulty and within ten minutes expired. Patient had a low-grade fever throughout this hospital course.

Dr. Margaret Jenkins (Conducting): Mr. Denham, please give us your analysis of the case.

Student Denham: This child suffered from a chronic debilitating disease which in an adult would suggest carcinomatosis. Tuberculosis and lupus erythematosus are other disease processes which have to be considered, but the negative PPD and the absence of L. E. cells rule against either of these. The degree of pulmonary involvement would also be unusual in lupus erythematosus. It seems to me that a malignant lesion of the gastrointestinal tract, either lymphoma, sarcoma or carcinoma would be the most probable diagnosis. One of the lymphoma group is most likely in a child. The nodule in the pelvis and the progressive infiltrative disease in the lung could easily represent metastatic foci. The pulmonary findings and the pelvic mass raise the question of tuberculosis with a tuberculous salpingitis or abscess, but this does not explain the gastrointestinal involvement and neoplastic disease can account for the entire picture.

Dr. Jenkins: Mr. Forlidas, please continue the discussion.

Student Forlidas: During the first admission, I certainly considered sickle cell disease most strongly. The muscular pains, headaches, anorexia and anemia all seemed to fit, but the S type hemoglobin is too low as it should be at least 40% to indicate sickle cell anemia. It appears then that the anemia is either of iron-deficiency type or from chronic blood loss secondary to gastric bleeding. The prominent rugal folds, mass in the pelvis and pulmonary infiltration cannot be related to sickle cell disease and certainly point to lymphoma at this age. It appears that the final episode was either bronchopneumonic in nature or possibly a manifestation of congestive heart failure.

Dr. Gadsden: In true sickle cell anemia we would expect to find 100% hemoglobin S and in the trait it would be around 50% by electrophoretic methods. In a child of this age the 0.71% fetal hemoglobin is not abnormally high. A level of over 2% indicates a failure in hemoglobin synthesis as might occur in a severe disorder such as sickle cell anemia or thalassemia.

Dr. Cheves Smythe: What did the pediatricians think about this case prior to postmortem?

Dr. Jenkins: We thought it was some sort of malignant process with a terminal bronchopneumonia.

Dr. Louis Jervey: If the gastric rugae were really impressively thickened, it would be more indicative of a lymphoma.

Dr. Charlton DeSaussure: In the initial phases of this patient's clinical course lead poisoning would have to be ruled out, but as time passed it appeared less likely.

Dr. Pratt-Thomas: *Final Pathological Diagnosis: Adenocarcinoma of Stomach with Metastases to Lungs and Lymph Nodes.*

Cancer is apt to be considered as a disease of adults or older people, but this case emphasizes that neoplastic disease is an important cause of death in children. It is true that malignancies of epithelial origin are uncommon in children and the usual neoplasms of childhood are those related to brain, bone, kidney, lymph nodes and blood. Carcinomas do occur in the young with sufficient frequency, however, to necessitate their consideration as this case graphically illustrates.

Although carcinoma of the stomach is most commonly a disease of late middle age it occurs in the second and third decades and I recall two patients in their early twenties who died from carcinoma of the stomach. It may well be that this is one of the youngest cases to be recorded, although I have found mention of a case 9 years of age.

Grossly and histologically it is a characteristic carcinoma of the stomach. Immediately distal to the cardio-esophageal junction, and situated primarily on the lesser curvature, is an elevated, ulcerated neoplastic mass (Fig. 1). There is an ulcerated furrow running through the center and the edges are thrown into broad mound-like elevations. The lungs present a remarkable picture. They are heavy, firm and full



Figure 1
Carcinoma of the upper portion of the stomach in a 13 year old girl.

and the pleural aspects are studded with innumerable nodular, granular and plaque-like masses of crisp, white neoplastic tissue (Fig. 2). On section the pulmonary substance was in large part replaced by neoplastic tissue.

Microscopically the carcinoma cells contain secretory

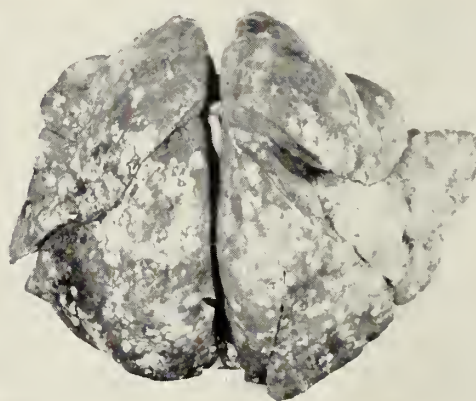


Figure 2
Extensive pleural and pulmonary metastases throughout both lungs.

vacuoles and some assume a signet-ring appearance due to the production of mucus. There is no distinct gland formation however. The tumor infiltrates through the entire thickness of the stomach wall and replaces the substance of regional lymph nodes. There are extensive metastatic deposits within the lungs with clusters of tumor cells filling veins and alveolar capillaries. There is also a heavy pneumonic exudate. The mass in the pelvic cul de sac is a neoplastic nodule.

Editorials

PEE DEE BULLETIN

The Pee Dee Medical Association has published a bulletin since 1948 under the able direction of Dr. Joseph P. Cain. It has served a very useful purpose as a means of informing the physicians of the Pee Dee area, and such others as are fortunate enough to be on the mailing list, of what goes on in medical, legislative, and humorous matters. With the February 1958 issue Dr. Harold S. Gilmore of Nichols took over the editorship, replacing Dr. Cain, who rests on his laurels of some 10 years' growth.

This *Journal* offers its best wishes for a happy continuation of the successful career of the *Bulletin*, and wishes the new editor all success and a minimum of headaches.

SPEECH

An article in a current medical journal is headed "Speech Correction for the Busy Physician" and while it actually refers to the doctors' patients, the title might well offer a glimmer of hope that the physician is to correct his own speech. It is probably too much to expect, and the struggle would be titanic. Even transferring the attempt to writing would be almost as difficult.

Lacking the means of underwriting and pursuing such a project, one might accomplish a great deal by quashing new verbal vipers as they arise, especially when they arise in the halls of science in the hospitals and clinics. A particularly horrendous example was heard lately when a patient was described as having a "Cushingoid" face! Comparison is obvious and odious with the term mongoloid for the child who resembles a Mongol. If Harvey Cushing ever looked like the puffy, moonfaced patient with Cushing's disease, we have been misled grossly by all the likenesses extant. "Cushingoid" is a term to be defaced.

However, all literary hope is not lost. In a pediatric protocol of recent date there was found a pathetic note suitable for an in-

scription for a small tombstone. The progressively fatal course of the infant's disease was described in staccato telegraphese, but the final sentence shed a poetic light on the gruesome account, for it said: "She died quietly on October 1, 1957, after nine weeks of life." *Requiescat in pace.*

WHO IS TO TEACH?

Last year the Congress appropriated \$211 million for the National Institutes of Health. Of this about \$53 million went to medical schools as research grants. From other sources a smaller sum came so that about \$75 million or more were spent on medical research by medical schools. Much, if not most, of this work was done by men who are either part time or full time teachers in medical institutions.

The man who is motivated to do investigative medicine is often also motivated to do some medical teaching and vice versa. The demand for doctors continues to be active, and yet the number of medical school graduates is barely keeping pace with the increase in the population. Personnel to do a large part of the \$75 million worth of research and to staff these programs must be recruited from present medical school staffs and from the supply of intellectually curious and creative men leaving the various training programs. Although the professional medical school teacher is recognized today in keeping with the progressive specialization affecting all parts of our society, the magnitude of this research commitment will necessarily increase the need for such full time medical school teachers. All medical schools are now committed to at least a nucleus of full time staff men. The energies of these men are going to administer increasingly complex medical school programs. Very large blocks of their time should be given to research. If medical teaching is not to suffer, medical school staffs must continue to grow, that is, if one admits the obvious necessity for

clinical teaching.

One must ask whether American medical schools have the intellectual potential to absorb with maximal productivity \$75 million worth of research effort and yet to maintain other commitments. Successful research remains the road to glory in academic medicine and most sensitive young men ambitious for success in this field are acutely aware of this. Practically anyone can do some form of research today. The end result has been a tremendous drain on teaching potential in many medical schools. Granting that nothing produces scholarship so effectively as an atmosphere in which research is done, increasingly one must ask if students are better taught because of the existence in their proximity of multiple research programs, hordes of clinical fellows, rows of laboratories into which they seldom venture, and larger staffs than in years gone by. The answer to this query must often remain in doubt and is sometimes negative. As highly desirable as the "undifferentiated doctor" may be, a school should turn out a product more easily recognizable as a physician than are men incompetent in the clinical setting because they have been nurtured on "do it yourself" clinical teaching because so much staff time has been consumed by laboratory commitments.

Schools need concern themselves with more than the financial drain or overhead of research programs. Teaching overhead is also high. Possibly the answer to this problem is not to increase the staff (research programs will not decrease and what institutions would dare utter such heresy), but to cultivate in clinical departments a coterie of men whose primary interest remains clinical medicine and whose primary medical school duty would be teaching clinical medicine. The "grosse kliniker" of a generation ago served a very useful function, and medical schools might well consider the cultivation of a modern prototype of these great clinical teachers.

Cheves Smythe, M. D.

ON MORBIDITY REPORTING

Recent professional and public interest in the spread of a new influenza strain from the Orient emphasizes again the important role of

practicing physicians as the first line of defense in community protection from major communicable diseases. Busy physicians, while seeing the vast majority of the seriously ill, are ever alert to either pathognomonic or bizarre signs and symptoms which may indicate a communicable state threatening to the community. By pooling our knowledge through established channels, we have available to us a continuous measure of the health status of our community.

Morbidity reports provide essential facts for the profession, and, through us, for the public. We must know what diseases are prevalent in order to guide our patients intelligently—to allay fears engendered by wild rumor, to recommend protective measures, to be alert for early symptoms and prepared with adequate prophylactic and therapeutic medications, and to advise persons exposed by chance or necessity. Periodic reports are the basis for necessary epidemiological studies which reveal factors associated with the occurrence of disease—season, location, age, sex, race, etc.

On the community level, morbidity reports furnish some indication of the degree of immunity present in component groups. They enable identification of sources of infection, secure health agency assistance in the establishment of necessary isolation, quarantine, and protection of contacts, and suggest research needs, sometimes urgently. They are an important guide for the expenditure of tax funds for public health measures.

By routinely participating, week by week, in systematized morbidity reporting, the physician is performing an essential service for himself, his patients, and his community.

Leon Banov

HOW'S YOUR MENTAL HEALTH?

The treatment of mentally ill persons has varied over the centuries. In the time of our Lord persons who were markedly different in behavior from their fellows were considered to be possessed of devils, and some of them had to live apart from other people, even in tombs. The American Indians were much kinder to their brothers afflicted in this way; they regarded them as under the special care and protection of the Great Spirit and allowed

them every latitude in their personal actions and protected them. In England several centuries ago, insane persons were locked in asylums where they suffered every sort of mistreatment including flogging in the effort to make them conform to standard practice. In the United States nowadays many people, some insane and some simply senile or feeble-minded, are committed to overcrowded, understaffed institutions where they are often conveniently forgotten by friends and family. This is not intended as any reflection on the staffs of such institutions as such, although many of them are subject to severe criticism. Many of them do the best they can under an overwhelming burden. In addition to all these standard activities as regards alleged insane people, certain families have not hesitated from time to time to attempt to put their aged and wealthy relatives into asylums for the purpose of possessing their goods.

A new wrinkle has now arisen. There are certain so-called "frontier thinkers", who are busy advocating a world government. They spend much time talking about the necessity of the peoples of the world adjusting to each other and of submerging individuality to the common good. They find that traditional beliefs and patriotisms are a hindrance toward the achieving of this goal. They have defined those who oppose them as being "rigid personalities" and have stated further that "such persons are well along the way to mental illness". It is further suggested that such persons should upon occasion be restrained and prevented from obstructing progress. There was a great deal of excitement last year over the so-called Alaska Mental Health Bill which many people, including the writer, felt was written in such a way that, as originally written, it would do more than provide for the care of the mentally ill, which was a worthwhile undertaking, but that in addition it might provide the means for incarcerating certain politically objectionable individuals. Because of strenuous objections from various sources about this aspect of the bill, it was revised considerably and some of the dangerous wording was removed. Of course the proponents of the bill denied that there was any possibility that it would be used for sinister

purposes. Those who claimed that it might be so used were termed the "lunatic fringe". It has been proven beyond reasonable doubt that certain persons in this country of ours have been sent to mental institutions recently because their actions were embarrassing to the federal government. The writer will merely cite the case of one of the Finn twins and of Lucille Miller. Both of these people were released after prodigious efforts in their behalf as sane. These were both federal cases. A similar case has now occurred in California which involved only the county government. It is the case of Mr. A. R. Fitzpatrick who in January 1957 attended a meeting of the county board of supervisors in San Luis Obispo County. He voiced objections and finally accused the chairman of being "disloyal to America". For this action he was incarcerated by the sheriff who certified that he was a "mentally ill person, in need of care and treatment". Mr. Fitzpatrick demanded a jury trial which he got. In the jury trial he was accused of being insane because of a persecution complex. More particularly, the psychiatrist testified that the persecution complex was the opinion that he was being persecuted because he had been sent to the hospital against his will after attempting to bring to the public attention errors in political and economic fields. The psychiatrist would not answer whether this opinion was true or not. The jury found that he was insane, and as far as the writer knows he is still in an asylum. The writer submits that there are other ways of dealing with people who are unruly at public hearings and these consist of prosecution for breach of the peace, libel, etc. To incarcerate such a person for insanity seems rather rough treatment.

There is a California state senator named Dilworth who is well known as a fighting anti-Communist and a good American in general. He has recently submitted a proposed amendment to the California constitution entitled "A Bill of Rights For Mental Health Patients" which reads as follows:

(a) No person shall be committed to or confined in a mental institution without a court hearing.

(b) No person shall be committed to or con-

fined in a mental institution unless he is afforded the right to a speedy public trial; to a trial by jury; to counsel of his own choosing, or if unable to obtain counsel, to a counsel appointed by the court; to be confronted by his accusers; to ample notice of the exact charges against him; and to compulsory process for the attendance of witnesses.

(e) It shall be the duty of the public defender, if appointed, to defend persons accused of being mentally ill or mentally deficient, and it shall be the duty of the court to appoint counsel for any such person, if that person is unable to obtain counsel of his own choosing.

(d) No person shall be committed to or confined in a mental institution because of his religious or political beliefs.

(e) No person shall be committed to or confined in a mental institution to prevent him from exercising his right of freedom of speech, including his right to express his political views and to criticize the government, any public official or any law.

(f) No person shall be committed to or confined in a mental institution to prevent him from exercising his right to assemble with his fellow citizens; to petition the government for the redress of his grievances; to lawfully possess arms; to resist unlawful searches and seizures; to engage in political activity; to resist the taking of his property; or to take appropriate action in defense of his children, parents or spouse.

(g) Persons accused of being mentally ill or mentally deficient shall not prior to adjudication of mental illness or deficiency be confined with and among persons previously adjudged mentally ill or mentally deficient except when no other facilities are available.

(h) Patients in a mental institution shall not be denied the right to counsel, or the right to communicate with persons outside the institution.

(i) No United States citizen shall be transported out of this State on charges of mental illness or mental deficiency of any kind unless it be to the state of his legal residence.

Enumeration of the foregoing rights shall not deprive a person accused of mental illness or mental deficiency of any other rights that he may have at law or in equity.

If a sober-minded and conscientious state legislator like Senator Dilworth feels that such a bill of rights is necessary in the state of California, it might be that we should pay more attention to the "lunatic fringe" which feels the hot breath of the booby-hatch warden on the back of its neck. Modern psychiatric treatment is such that properly misused it could render an obnoxious person quite harmless permanently in a very short time.

Thomas Parker, M. D.

STATE BOARD OF MEDICAL EXAMINERS
OF
SOUTH CAROLINA

Columbia, S. C.

January 2, 1958

Chairman for the

Committee for Interns and Residents

At the meeting of the State Board of Medical Examiners of South Carolina on December 10, 1957, the Board had as its counselors, Mr. McLeod, from the Attorney General's Office and Dr. John T. Cuttino, Clinical Director of Roper Hospital. This letter is to aid in clarifying the policy of the Board with respect to the issuing of Temporary License Permits for interns and residents. The program for the licensing of interns and residents in accredited hospitals is now in effect.

- (a) Qualified residents in a formal training program will be issued a Temporary Permit at a fee of \$15.00. This Permit is to be renewed each year on the payment of the above fee and may be renewed at yearly intervals as long as he or she is in training. (Prior to this time residents were required to have a permanent license.)
- (b) The status of the interns' Permits remains unchanged. Interns and residents are under the law practicing medicine, and all should be duly licensed. A temporary license is obtainable by all qualified physicians working in a hospital approved for intern or residency training; licenses are not obtainable on a temporary basis by those acting as interns or residents in institutions unapproved for such training. Physicians in such institutions are required to have permanent licenses.
- (c) Graduates of accredited Canadian Medical Schools will be accepted even though not citizens of this country, provided they sign a declaration of intent.
- (d) In order to more efficiently check the status of the house staff of the hospitals, it is desired that all Temporary Permits be kept in a central and easily accessible location within the hospital. It is contemplated that at irregular intervals either a member of the Board or an inspector from the hospital division of the State

Board of Health will drop by and check on the current status.

- (e) It will be the policy of the Board as of February 1, 1958, not to consider the Temporary Permits valid and in effect unless countersigned by the chairman of the intern committee, clinical director or chief of staff (or licensed physician responsible for intern training).

George R. Wilkinson, M. D.
President

EDUCATIONAL COUNCIL FOR

FOREIGN MEDICAL GRADUATES

After almost three years of planning, the Educational Council for Foreign Medical Graduates opened its doors on October 1, 1957 at 1710 Orrington Avenue, Evanston, Illinois.

What Functions Will It Serve?

It will distribute to foreign medical graduates around the world authentic information regarding the opportunities, difficulties and pit-falls involved in coming to the U. S. on an exchange visitor or exchange student visa in order to take training as an intern or resident in a U. S. hospital, or coming on an immigrant visa with the hope of becoming licensed to practice.

It will make available to properly qualified foreign medical graduates while still in their own country a means of obtaining ECFMG certification (a) to the effect that their educational credentials have been checked and found meeting minimal standards (18 years of formal education, including at least 4 years in a bona fide medical school), (b) that the command of English has been tested and found adequate for assuming an internship in an American hospital, (c) that the general knowledge of medicine as evidenced by passing of the American Medical Qualification Examination is adequate for assuming an internship in an American hospital.

It will provide hospitals, state licensing boards, and specialty boards which the foreign medical graduate designates, the results of the three-way screening available.

What Functions Will It Not Serve?

It will not serve as a placement agency either for interns or residents. Placement arrangements must be made by the foreign medical graduate directly with the hospital of his choice.

It will not attempt to evaluate the teaching program or inspect or approve any foreign medical school. Its program is based not upon evaluating the school from which the candidate graduated but upon evaluating the professional competence of the individual.

It will not act as an intercessor for foreign medical graduates having problems under discussion by state boards of medical licensure or specialty boards. If the foreign medical graduate asks that the results of his three-way screening be sent to a designated board this will be done, but the ECFMG has no right and no desire to review the decisions of the properly con-

stituted state licensing boards and American specialty boards.

Who Is Sponsoring the ECFMG?

Sponsors of the new agency are the American Hospital Association, the American Medical Association, the Association of American Medical Colleges and the Federation of State Medical Boards of the United States. Providing funds to support it through the first two years of its existence are the sponsoring agencies and the Kellogg Foundation, and the Rockefeller Foundation.

The ECFMG has been legally incorporated in the State of Illinois and is operating in the first year of its provisional approval as a tax exempt organization under Section 501 (c) (3) of the *Internal Revenue Code of 1954*. The 10-member Board of Trustees includes two representatives from each of the four sponsoring agencies and two representing the public at large (one named by the Department of Defense, the other by the Department of Health, Education and Welfare). The President of the Board of Trustees is Dr. J. Murray Kinsman, Dean of the University of Louisville School of Medicine. The Executive Director is Dr. Dean F. Smiley, former Secretary of the Association of the American Medical Colleges.

What Are the Mechanics of the Examination?

The ECFMG's Examination Committee will select the items for two examinations a year from the National Board of Medical Examiners' pool of questions. The National Board of Medical Examiners will use as many of its 50 presently constituted U. S. examination centers as will be required and will establish examination centers abroad in numbers as found required to meet the need.

The National Board of Medical Examiners will proctor the examination, score and analyze the results, and turn them over to the ECFMG's Examination Committee for final evaluation and action.

What is the Charge to Be?

Foreign medical graduates already in this country will be billed for \$50.00 covering the cost of the three-way screening. This will include \$15.00 for the evaluation of credentials and \$35.00 for the American Medical Qualification Examination.

Foreign medical graduates abroad will be billed the \$50.00 only if and when they pass the screening, receive a position in an American hospital or are otherwise earning American dollars.

American hospitals receiving screened candidates will be billed \$75.00 for each such candidate accepted.

What Are the Target Dates for Various Services?

The answering of correspondence began October 5th and has been kept current since that time. The translation, interpretations and evaluation of credentials has already begun.

The target date for the first American Medical Qualification Examination for foreign medical graduates already in this country is set for February or March, 1958.

The target date for the second American Medical

Qualification Examination for foreign medical graduates both here and abroad is set for August or September, 1958.

TODAY IS ANOTHER DAY

Very few doctors have failed to take advantage of all the changes — advances — of modern practice. Methods of treatment, medications, and technics of the earlier ages have been improved or discarded. However, judged from complaints of many patients, too many doctors still regard the economics of their activities in terms of a philosophy which was outdated nearly half a century ago.

The seniors of our profession will recall the days when much of the doctor's service was performed with no thought of gainful reward. When a patient had no money, the doctor expected no pay. The acceptance of token payments was quite common. A doctor who collected the "normal fee of the time" from more than a third of his patients was exceptional.

It is different today. Save for a small fraction of down-and-outers, all others are able to pay for their care—some out of their own ample financial resources but the vast majority out of voluntary nonprofit or other indemnity source.

The medical societies have agreed on certain sums of subscriber income below which levels the patient should receive paid-in-full care from a doctor who has signed to participate. Any doctor who is unwilling to abide faithfully by this obligation should not sign the participating membership agreement. A violation of such bargain is a breach of integrity and pocket-picking dishonesty, and it reflects on the whole profession. Fortunately, only a small minority bring this discredit on us. Need it be said here, a small leak can sink a big ship?

The license to engage in medical practice does not convey a "vested ownership." It can be suspended, conditioned, or revoked as best suits the general public welfare, and the legislators sit in authoritative judgment on what that may be. Our conduct must not be provocative. We cannot afford to permit the destruction by a few of the reputation and good will created by us under the compensation law.

In earlier times it was condoned conduct for a doctor to play the role of a Robin Hood—some patients were charged high fees, others less, and some none. Under our present community life many are charged fees which inflict hardship, and these victims have no defense or recourse. It is embarrassing to a patient to feel deep appreciation for what was done and at the same time to resist and resent "being done." In those days the relations of the doctor with his public was blissfully simple; he was master of his own house, the "Lord of a Manor."

The doctor who says "No one can tell me how much I can charge my patient" is a misfit in our modern doctor-patient economy. The "provider" of medical care (the doctor) and the "buyer" (the patient) are living in new social environments. The "provider"

need no longer collect and distribute benefits, and the "buyer" is no longer without formidable defense resources.

When a doctor who has agreed to the paid-in-full provisions and who in spite of them lays an added charge on a patient who qualifies for paid-in-full care, three different channels of complaints are apt to flow from his action. Officers of our medical societies hear about it, the administration of the plan hears of it, but of much greater consequence the labor union leaders hear about it. Few doctors know or stop to think of this third party. Forty million voters can now speak for the "buyers" of doctor care if they have been or think they have been unfairly treated.

The shortest and quickest way to bring political controls on the practice of medicine is to falter in the support of our program and thereby invite the power of labor to join forces with the politician who wants to bait his hook with "medical care without cost to you." Anyone who thinks a few thousand doctors with divided ranks and opinions can exercise greater influence than millions of united voters needs the services of a psychiatrist.

The cars of many of us still ring with the outbursts of oratory released by the mere mention of a "fee schedule" during meetings of our House of Delegates. The brains of intelligent men were frozen with fear by the prediction that any schedule would be but the prelude to socialization or compulsory health insurance. Today we hear the same croaking because the Federal government has gotten around to payment of doctors for the care of military dependents under Medicare.

Yet, in 1935 the New York State Workmen's Compensation Law was amended to include a "minimum fee schedule." Our Society was caught napping—the Economics Committee had been inhibited from the completion of a schedule. The orators were silenced, and by dint of a very great effort the situation was salvaged.

Twenty years of experience has demonstrated that free choice of doctor by the injured—scheduled-fee-for-service to the doctor—with the exercise of responsibilities in the administration of the law on the part of the county medical societies has eliminated most if not all of the evils which had developed under the original compensation law, and no doctor complains of being hurt, even though the schedule provides full payment regardless of the worker's income.

Abuses threaten to develop under the voluntary insurance law (Article IXc), and they can be expected to grow serious if splinter groups make deals with doctor groups to provide coverage "just like Blue Shield's" with nondoctor controls.

It will be too late to step in after the wrongs pass the limit of tolerance. The leadership of the local societies had best begin planning to take their proper position of cooperation and administrative responsibilities in this field of medical practice if the freedom of the patients and their doctors is to be preserved. If allowed to just drift we'll be doomed to political

slavery. This is my job, your job, our job—every doctor's job. Now or never.

Reprinted by permission of the author, Dr. F. E. Elliott, from the *New York State Journal of Medicine* 58:180 (Jan. 15, 1958)

REPORT OF A DELEGATE
A. M. A. CLINICAL MEETING IN
PHILADELPHIA
DECEMBER 1957

The number of physicians in the A. M. A. increased by 3,430 over the previous year ending June 30, 1957. There were 133,034 active paid members of the A. M. A. as of that date. Total membership includes active members exempt from dues 10,216, associate members 6,127, service members 14,059, affiliate members 200, and honorary members 91. This makes a total membership of 163,817. South Carolina had, on June 30, 1957, 1,741 physicians in the state. A total of 1,230 doctors are members of the A. M. A. which is an increase of 88 over the previous year.

The annual meetings have been set for the following places and times:

	1958	San Francisco	June 23-27
	1959	Atlantic City	June 8-12
	1960	Chicago	
	1961	New York	
	1962	San Francisco	
Clinical	1958	Minneapolis	Dec. 2-5
	1959	Dallas	Dec. 1-4
	1960	Washington, D. C.	

The average weekly paid circulation of the *Journal* of the A. M. A. was 174,587—a 12,574 increase over the previous year. All the nine specialty journals showed an increase in circulation over the previous year. The *Journal*, although printed primarily for the American Medical membership, is international in its distribution and goes to 100 different countries.

Among the more important items considered at the Philadelphia meeting were the Heller report and flouridation. The Heller report is the result of a year's study by a separate corporation versed in the operations of corporations. Every phase of the A. M. A. was gone into and a committee appointed by the speaker of the house gave its recommendations and suggestions after several months of careful study. The committee from the house endorsed some of the suggestions in the report and condemned others. Some of the suggestions related only to operations within the A. M. A. headquarters which would automatically come under the supervision of the General Manager (or Executive Vice President). The reference committee of the House of Delegates approved some and disapproved other parts of the committee's report. This is an important phase of the A. M. A. and every doctor should read the Heller report or the ultimate report as it comes out in the *Journal* of the A. M. A.

Flouridation of communities' water supply in the amount not to exceed 1 ppm. was endorsed as an effective and safe method of preventing caries in the

teeth of children. This was in line with the report of two councils each of which studied all the facts on the subject. One of the most important reports was that of a man with the Sloan-Kettering Institute who reported on a series of cases that were constantly exposed to relatively large amounts of flourides in industry. They showed no ill effects and the excess flourides were eliminated. It seems from the exhaustive study of these two councils that doctors can safely and conscientiously recommend flouridation of a community water supply.

The House of Delegates of the A. M. A. went on record as advocating the "discontinuance of the use of flourosopes for the fitting of shoes". New York and Pennsylvania among others have laws prohibiting their use.

Of interest to all doctors who treat patients that may receive compensation for injury is a report to be published in the *Journal* of the A. M. A. early in '58. It is 115 pages long and has diagrams and pictures to illustrate it. It is a guide to medical rating of physical impairment. To all generalists, surgeons, orthopedists, and physiatrists it would seem that this publication would be indispensable. It must be remembered though that it is only a guide and neither a set of rules nor laws.

The reference committee on medical service recommended that when each state renegotiates its contract with the Department of Defense that it seeks whatever type payment it chooses whether fixed fee or indemnity type payment.

The physicians in the states where the United Mine Workers operate are up in arms because of discrimination by the U. M. W. Welfare fund. It will agree to pay only certain doctors and certain hospitals. The argument of the fund is that the hospitals and doctors not on their approved list are the ones who are making charges out of line with other doctors and hospitals in that area. The doctors involved claim that this is not true—and so it goes.

The reference committee urged that the A. M. A. and the A. H. A. recommend to their constituent associations that joint medical and hospital liaison committees be appointed at the state level to study ways and means to lessen professional and hospital liability. On the national level this committee has already begun its work.

The work of the committee on aging is increasing by leaps and bounds. Its chairman, Dr. Mulholland of the University of Virginia was in constant demand as a speaker on panels until his illness. Because of the increasing numbers of older people every state medical association is urged to have separate committee on aging as 13 states have, or a subcommittee such as medical service—11 states have this arrangement.

The reference committee on insurance and medical service urged that state and county medical societies participate actively in the planning and operation of medical care programs for the indigent. The next step in federal patronage will probably be in this direction.

It was also urged that an official liaison between medical societies and medical schools be formed. This body would be used to help solve problems that may arise concerning the private practice of medicine or that may be assisted by the medical profession. This is not the ultimate solution but is certainly the only rational solution.

A set of Guiding Principles for an occupational health program in a hospital employee group has been drawn up by a joint committee of the American Medical Association and the American Hospital Association. It has been approved by the A. H. A. as well as the House of Delegates.

The Reference Committee on Legislation and Public Relations endorsed the efforts of the Committee on Legislation to keep physicians informed as to the goings on. The work involved in the Washington office of the A. M. A. is tremendous and all concerned deserve the thanks of every physician. The office of the A. M. A. is an effective means of information for the physicians of the nation as well as for the legislators. It does not decide any policy but suggests that in the light of previous policy such and such may be acceptable or unacceptable to the A. M. A. as the case may be.

During the discussion concerning Public Relations it was brought out that there is difficulty in getting information from the A. M. A. to the new members. The consensus of opinion was that this can best be done at the local level—the county medical society.

The report of the American Medical Education Foundation is interesting to every physician. During the past six years American physicians have given more than six million dollars to the A. M. E. Foundation for Medical education. In the calendar year 1956 income to the fund was \$1,072,727.00 or 40% increase over the same 12 months in 1955. In February 1957 the A. M. E. Foundation divided \$1,072,365.71 among 83 medical schools. Of this amount, according to a predetermined formula, \$551,425.00 of undesignated and \$520,940.71 of designated money were granted. The importance and deep appreciation of this money can be learned from the grateful letters of deans and presidents of medical schools. Remember a dollar through the A. M. E. F. brings three more from the National Foundation for Medical Education. When a doctor gives to a medical school he should stipulate his choice and send it to the A. M. E. F.

It is impossible to mention every item considered at a meeting of the House of Delegates. It is boring to have to wade through every printed paragraph that details the program. If there is any item that any physician is particularly interested in simply contact Dr. William Weston, Jr., or me and we will be glad to dig it out.

George D. Johnson, M. D.

DID YOU KNOW?

That there were 2,160 participants in the A. M. A. Scientific Assembly in New York?

That the film library of the American Medical Association has 1001 of 168 subjects?

That 4,095 films were lent during the year—an increase of 591 over the previous year?

That your A. M. A. has 51 health exhibits which were displayed at 159 locations in 34 different states?

That a total of 761 queries were received from the television audience of the Ciba program "Medical Horizons"?

That in the question and answer department most questions (3,232) were about plastic surgery and the second largest (1,038) about medical guidance (high school students)?

That in radio the A. M. A. distributed 1,355 sets of transcriptions from which a total of 20,633 individual broadcasts were made?

That the Bureau of Health Education now carries 303 health education pamphlets?

That in April 1957 the Canadian Parliament and in the summer of 1956 the Parliament of Great Britain passed counterparts to the Jenkins-Keogh bills?

PSYCHIATRIC SPEAKERS BUREAU

The General Practitioner Education Project, jointly sponsored by the American Psychiatric Association and the American Academy of General Practice, is interested in the development of post-graduate psychiatric education for the family physician. One of the services which is offered by the Project is a Speakers Bureau, which is prepared to offer names of psychiatrists who are willing to serve as guest lecturers while they are taking their vacation trips. Medical societies, hospitals, etc. which are interested in obtaining names of psychiatric speakers, please contact the G. P. Project, American Psychiatric Association, 1785 Massachusetts Avenue, N. W., Washington, D. C.

CORRESPONDENCE

SOUTHERN MEDICAL ASSOCIATION

January 17, 1958

Dear Dr. Waring:

Dr. Waring, I was happy to see your editorial on the Southern Medical Association in the November issue of the South Carolina Journal.

I would like to tell you that we had 43 physicians from South Carolina at our Miami Beach meeting. While this is not a large number, it does compare rather favorably with some of the states of similar size and distance from the meeting.

We are all very proud of our Councilor, Dr. Jack W. Jervcy. He is one of the most enthusiastic members of the Council and is doing a great deal to promote interest in the Association. He works continuously for membership, for contributions to our Building Fund and the other activities of the Association.

During the Miami Beach meeting the Southern Medical Association conferred its Distinguished Ser-

vice Award on Dr. Kenneth M. Lynch. The award was presented during the Annual Dinner Meeting, and in the event you have not seen it, I am enclosing a copy of the January Journal which carried an editorial on the award as well as a photograph of the presentation.

We also have some fine Section Officers from South Carolina, including: Dr. Kelly T. McKee, Secretary, Section on Medicine, Charleston; Dr. Gerald E. McDaniel, Chairman, Section on Public Health, Columbia.

We are grateful for this support, and we want to thank you for your interest and particularly for your editorial.

Very sincerely yours,
V. O. Foster
Executive Secretary-Treasurer

NEWS

COUNTY OFFICERS MEETING

A meeting of the officers of the county Medical Societies of South Carolina was held on Sunday, January 26, at 12:30 at the Columbia Hotel, with about 40 physicians present.

Dr. Robert Walton of the Medical College told about what is going on there with suggestions as to who might be good speakers for county meetings. He mentioned that speakers might be obtained on the subjects of the artificial kidney, diabetes, mental evaluation, neurology, heart surgery, lipoproteins, radiation, obstetrics, psychiatry, neurosurgery, plastic surgery, and hematology.

Mr. M. L. Meadors explained the various classes of dues and the collection of these through the county treasurers.

Dr. George Johnson spoke about Blue Shield and its need for wholehearted support. He noted that the requirement for malpractice insurance has been removed. Three counties still do not approve the Plan, Oconee, Georgetown, and Greenwood. Progress is being made, but only 5 per cent of the population hold policies and benefits are limited by the small number of policyholders. Dr. Johnson emphasized that Blue Shield was still a bulwark against socialized medicine, and that it requires much unrewarded work by the Doctors in administrative positions. He noted that amiable complaints were welcomed.

Mr. Meadors also spoke on the Legislative program, and saw no immediate threat to the profession.

Dr. J. I. Waring told about the *Journal* and its needs, especially its needs for contributions of papers, news, etc.

Dr. John Pratt, Chairman of the Committee on Allied Professions, offered suggestions as to how better cooperation between the doctors, lawyers, dentists and druggists can be obtained.

Dr. Tom Alphin, Director of our office in Washing-

ton, gave an interesting talk on national medical affairs.

DR. KING BEGINS MEDICAL PRACTICE IN NEWBERRY

Dr. W. W. King, Jr., son of Mr. and Mrs. W. W. King of Batesburg, began general medical practice on December 2, in Newberry.

For the past year Dr. King has served his internship at Columbia hospital in Columbia. He graduated from The Medical College in Charleston in 1956.

Dr. William F. Early of Darlington, who has practiced medicine at the Wilson clinic for the past year has announced the opening of his own offices at 120 Exchange Street for the practice of general medicine, surgery and obstetrics.

He served for five years in the U. S. Army, three years of which were spent overseas as an infantry captain. Later he was affiliated with the advertising department of Life magazine in New York and Virginia for three years prior to entering the University of Virginia at Charlottesville for his medical training.

After receiving his medical degree, Dr. Early served his internship and general practice residency at the Norfolk General Hospital, Norfolk, Va. He practiced in Timmons ville before coming to the Wilson clinic in Darlington in January, 1957.

He is a member of the American Medical Association and the South Carolina, Pee Dee and Darlington County Associations.

BERKELEY COUNTY HOSPITAL STAFF

At the recent meeting of the Berkeley County Hospital Staff, Dr. J. N. Walsh was reappointed Chief of Staff, and Dr. Robert S. Solomon was reappointed secretary. Dr. H. H. Addlestone and Dr. A. E. Rawl, of the Radiology Department of The St. Francis Xavier Hospital, Charleston, were appointed Consulting Radiologists. They will visit the hospital on Tuesdays for the purpose of carrying out diagnostic procedures and interpretation of x-ray film. Dr. Dale Groom, Cardiologist from the Medical College of South Carolina, will continue as Consulting Cardiologist.

Edward F. Parker, M. D., Charleston, Diplomate of the American Board of Surgery and of the Board of Thoracic Surgery announces the limitation of his practice to Thoracic Surgery including Cardiovascular Surgery.

"The Heart, Patient Under Stress, Work and Pregnancy" was a film shown at the regular second month meeting of Horry County Medical Society on Tuesday, January 14, at The Reef.

Dr. Ray Russell of Conway was elected as an alternate delegate to the South Carolina Medical convention was the principal item of business.

Twenty-nine of the thirty-three membership were

present for the meeting. Dr. Cary T. DuRant is president of the Society.

LIBERTY LIFE PAYS HONOR TO DR. FEWELL

Dr. Will S. Fewell, 65, prominent Greenville physician who is retiring as medical director of Liberty Life Insurance Co., January 1, was honored December 30 at a special luncheon in the company's home office private dining room.

Dr. Fewell has directed the medical aspects of the company's underwriting activities for the past 25 years as well as serving on the board of directors. He will continue, however, to serve Liberty Life in an advisory capacity.

President Francis M. Hipp presented Dr. Fewell with several awards, including a service emblem, wrist watch and a framed testimonial signed by 300 of his home office associates.

The testimonial read:

"Wishing to express our lasting gratitude for his valued influence and friendship, we, his home office associates, happily pay tribute to our 'Dr. Will' and extend to him our fondest hope for abundant pleasure during his years of retirement.

"Our legacy of cherished memories of this dedicated and compassionate man is incalculable, for his inimitable wit and profound understanding have constantly enriched our lives and increased our affection for him."

Dr. Fewell retired from the active practice of medicine in March, 1953, after 30 years as a physician in Greenville. He had been associated with his twin brother, Dr. John M. Fewell, who continues active.

A native of Rock Hill, he was educated at Presbyterian College, the University of North Carolina and the University of Pennsylvania Medical School. He is a member of the American Medical Association, the Greenville County Medical Society, the Association of Life Insurance Medical Directors of America and the Medical Section of the American Life Convention.

Appointment of Dr. Jay Hammett, Gaffney physician and surgeon, as a member of the governing board of the Cherokee County Memorial Hospital was announced recently.

The appointment, which filled the only existing vacancy on the nine member board, was made by the Cherokee County legislative delegation.

DR. KAY MEDICAL SOCIETY PRESIDENT

Dr. Charlotte Kay, of Liberty, was elected President of the Pickens County Medical Society at a meeting of the society held at the country club. She will succeed Dr. J. A. White, of Easley, outgoing president.

Other officers include: Dr. C. F. Higgins, Easley,

vice-president; Dr. E. A. Jamison, Easley, secretary-treasurer; Dr. Robert Jeanes and Dr. J. H. Jameson, both of Easley, delegates to the state medical meeting.

HOPE HOSPITAL REOPENS AFTER GETTING PHYSICIAN

Closed since June 1, 1957 for lack of a doctor, Hope Hospital has reopened its doors.

The 12-bed institution is also known as Lockhart Health Center.

Dr. John A. McLeod, Jr., will staff the hospital. Serving with him will be four nurses, a laboratory technician and a dietitian.

The nursing staff system will enable the hospital to have someone on duty at all hours. A modern operating room will have all necessary equipment for minor surgery.

There are four semi-private rooms and one ward of four other beds. Nursery equipment includes an incubator and four bassinets.

Other facilities of the hospital include a nurse utility room, doctors shower room, nurses shower room, work room, delivery room, x-ray chambers, kitchen, laboratory, reception offices and office for Dr. McLeod.

COLUMBIA MEDICAL SOCIETY HEADED BY DR. W. S. HALL

Dr. William S. Hall, superintendent of the South Carolina State Hospital was elected president of the Columbia Medical Society at the group's annual meeting at the Hotel Columbia December 9. He succeeds Dr. G. S. T. Peebles.

Chosen to serve with Dr. Hall were Dr. John R. Harvin, vice president; Dr. R. F. Haines, secretary and Dr. R. G. Latimer, treasurer. Dr. Buford S. ChapPELL was re-elected as editor of The Recorder.

Dr. Tucker Weston was elected a member of the public relations committee and Dr. C. F. Crews was elected a member of the Board of Censors.

Delegates to the South Carolina Medical Association named were Dr. Frank Owens, Dr. Waitus Tanner, and Dr. Chapman J. Milling.

Three alternate delegates named were Dr. W. T. Barron, Dr. R. B. Josey, and Dr. C. J. Lennon.

The Anderson County Medical Society held its December meeting at the Calhoun Hotel. Dr. Orr discussed the "Surgical Aspects of Bronchiectasis."

The Anderson surgeon is a native of Pendleton, a graduate of Clemson College and the Medical College of South Carolina, and interned at Columbia General. He did resident surgery at Spartanburg and served in the Army from 1944 to 1946 as a member of the auxiliary surgical team for the Third and Seventh Armies. Following armed service duty, he was a resident in general and thoracic surgery at McGuire Hospital, Richmond, Va.

KERSHAW COUNTY HOSPITAL

The public got its first good look at the new Kershaw County Hospital as "Open House" was observed on January 12. Transferring patients from the old to the new hospital began promptly.

With its completion and the future completion of the nurses Home-Training School, Kershaw County will have a hospital plant valued at approximately \$2 million.

The ultra-modern hospital stands ready to serve the public. For the personnel who will staff it, the new hospital offers the very latest in equipment and the best in working conditions.

The lighting of the corridors and rooms has been carefully planned.

Patients who will occupy the 118-bed hospital will find their rooms cheerful. The corridors and rooms have been painted in light, pastel colors of pink, green and blue.

The new hospital has two operating rooms. There are also two delivery rooms.

There are large and efficient heating and air-conditioning systems.

ANDERSON COUNTY

Dr. Kenneth M. Lynch, president of the Medical College of South Carolina in Charleston, was the speaker at the January meeting of the Anderson County Medical Society. Dr. H. J. Hancock, new president, and other new officers assumed their duties.

Dr. Lynch spoke on "Medical Education in South Carolina." In addition, Dr. J. W. Wyman, member of the Society, spoke on "Usual and Unusual Infections". He initiated a new practice of the Society to invite a local physician to deliver a 10 or 15 minutes paper in addition to hearing an out-of-town speaker each month.

Dr. Hancock succeeds Dr. James Halford as president of the Society. Dr. Halford is the Society's delegate to the State Medical Association. Other new officers include Dr. Rudolph Hand, vice president; Dr. Jay Jackson, treasurer; and Dr. William F. Lummus, secretary.

COURSE IN MEDICAL TECHNOLOGY SET

A joint Medical College - College of Charleston medical technology program has been announced by the two colleges.

Dr. Kenneth M. Lynch, president of the Medical College of South Carolina, and Dr. George D. Grice, president of the College of Charleston, said they were pleased to make available the broader educational service.

Training under the joint program will consist of three years of academic work and 15 months of specialized training at the Medical College.

Completion of the program will make a student eligible for a bachelor of science degree from the College of Charleston as a registered medical technologist.

Spokesmen at the two schools said the broadened program would provide South Carolina patients with additional medical services, of which there is now an acute shortage.

Dr. Grice said the program would provide increased opportunities for women students in a semi-professional field in which 50,000 job possibilities now exist.

Both colleges will include the joint courses in their 1958 fall bulletins.

DR. CARDWELL HEADS PATHOLOGISTS

Dr. Edward S. Cardwell, Jr., of Columbia, is the new president of the South Carolina Society of Pathologists, having been named to this post at the annual business meeting of the society December 14 at the Veterans' Hospital.

Following a scientific session, the annual business meeting was held and new officers chosen.

Other new officers named were: Dr. Hunter May, Greenwood, vice-president; Dr. McKenzie Moore, Charleston, secretary-treasurer; Dr. Donald G. Kilgore, Greenville, councillor; Dr. E. Arthur Dreskin, Greenville, assemblyman.

Retiring officers are: Dr. H. Rawlings Pratt-Thomas, Charleston, president; Dr. Edward S. Cardwell, Jr., Columbia, vice-president; Dr. E. Arthur Dreskin, Greenville, secretary-treasurer.

South Carolina has received two grants for research from the Easter Seal Research Foundation sponsored by the National Society for Crippled Children and Adults, Inc.

Each year two per cent of all funds raised through the Easter Seal Campaign are earmarked for the Research Foundation. South Carolina's share, coming from all counties, amounted to \$3,267.52 for 1957.

The two grants which were awarded to the South Carolina Medical College total \$10,265.00.

Two consultants in medicine at the Mayo Clinic spoke at a meeting of the Sumter-Clarendon Medical Society January 9.

The two, Dr. E. V. Allen and Dr. E. H. Ryncarson are professors of medicine in the graduate school of medicine of the University of Minnesota.

A 34-bed addition to the Byerly Hospital at Hartsville is planned for the near future. Administrator E. L. McLaughlin said today.

"It is expected that the contract for construction will be awarded May 1. It will require about 10 months to complete the addition to the hospital," he said.

Cost of the construction will be \$300,000, according to the administrator.

"It is being financed partly by Hill-Burton funds and partly by local funds," he explained.

Darlington's city council, at its first meeting of the new year paid tribute to Dr. J. M. Willcox who, for the first time in over a quarter of a century, is not serving as a member.

Willcox, mayor protem for many years, did not offer for re-election. Mayor Thomas W. Buchanan and City Attorney J. F. Pate praised Dr. Willcox for his many years of service. Dr. Willcox, who was a special guest at the meeting was presented a gift of appreciation by Pate on behalf of the council.

Dr. Dan F. Moorner has been granted a license by the South Carolina State Board of Health to operate a clinic in Latta to be known as the Latta Hospital.

Latta's first hospital, it has a two-bed facility and a staff of a registered nurse, a technician and two practical nurses.

Licensed to take any type of patient the hospital aims at present at providing emergency service and the handling of obstetrical cases.

Dr. Horace M. Whitworth was named president of the medical staff of Greenville General Hospital recently. Other new officers named were Dr. Frank Stelling, vice president, and Dr. Joseph C. Moore, secretary.

Dr. Jay Hammett, Gaffney physician and surgeon, has been appointed to the Cherokee County Memorial Hospital governing board, bringing the board's membership to nine.

Dr. H. H. Harris, a native of Anderson, where he practiced medicine and surgery for a number of years, has located in Calhoun Falls with offices in the former Dr. Love Clinic, to begin the practice of medicine and surgery here. Dr. Harris came here just before Christmas.

While his home is Anderson, Dr. Harris, recently returned from Las Vegas, Nevada, where he practiced the past year. Dr. Harris' father was also a well-known Anderson physician and surgeon.

The location of Dr. Harris here gives the community three doctors of medicine, the other two being L. P. Elam, Jr., M. D. and George W. Fort, M. D.

NEW YEAR'S MEETING IN BENNETTSVILLE

The 38th Annual New Year's Meeting of the Marlboro County Medical Society was held at the Bennettsville Country Club on Thursday, January 9, 1958.

As has been the custom for the last ten years, this January meeting was held in cooperation with the Pee Dee Medical Association as its regular monthly meeting. The group convened for a social hour starting at six P. M. which was most enjoyable and many old friends were greeted who had not been seen since the last New Year's meeting. One observer reported that the ever increasing number of new faces seems to emphasize the fact that most of us feel so strongly

that some of us have been around here a mighty long time.

The Junior League of Bennettsville served a delicious supper with an ample supply of oyster pie, which in itself makes this meeting worthwhile without the other trimmings of which there were plenty.

Presiding over the meeting was Dr. Jenks Owens of Bennettsville, President of the Association. He introduced Dr. Kenneth Lynch, President of the Medical College of South Carolina, who is an honorary member (so far as is known, the ONLY honorary member) of the Marlboro Association. Dr. Lynch traced the progress of the Medical School to date and spoke briefly concerning many of its problems—particularly those of a financial nature, requesting that all doctors in attendance cooperate with the Medical College in influencing the Legislature to favorably solve its fiscal dilemma.

The Scientific program was well received, being an address by Dr. Harold S. Pettit, Professor of Radiology at the Medical College of South Carolina, who spoke on "Collagen Diseases," and particularly emphasized their roentgenological findings.

Two new physicians have located in Greenwood and both are associated with Dr. S. D. Pendergrass in the general practice of medicine. They have offices in the Medical Arts building.

Dr. Guy Calvert and Dr. T. Jackson Wood are the new physicians. Both are graduates of the University of South Carolina and Bowman-Gray Medical School in Winston-Salem, N. C.

Dr. Calvert is a native of Columbia. He served his internship at the U. S. Naval Hospital in San Diego, Calif., spent three months at the National Naval Medical Center, Bethesda, Md., studying X-ray interpretation and the last 14 months stationed at the Charleston Navy Yard.

Dr. Wood also has just completed naval service. He had sea duty for a year and for the last six months has been at the Naval Hospital in Beaufort. He is a native of York.

Dr. Harwood Beebe, Jr., was elected president of the medical staff of the Mary Black Memorial Hospital, Spartanburg. Dr. David Stack was elected secretary.

KREDEL ADDRESSES MEDICAL SOCIETY

Dr. F. E. Kredel head of the department of surgery at the Medical College of the State of South Carolina, Charleston, was speaker at the January meeting of the York County Medical Society at the Andrew Jackson Hotel.

Dr. Alton G. Brown is president of the county society.

Dr. Kredel gave an illustrated lecture on pancreatitis.



Navy Doctor prepares a patient for a cornea transplant operation at the Beaufort Naval Hospital. The cornea used on the patient was donated through the "South Carolina Eye Bank Inc."

(Official Marine Corps Photograph)

Dr. S. Hunter Rentz has announced the opening of offices in the general practice of medicine in Columbia.

Dr. Rentz was born in Columbia. He entered the University of South Carolina in 1949 and was graduated with a B. S. Degree in Chemistry.

His medical education was acquired at the Medical College of South Carolina where he graduated in December 1956 and he has recently completed his internship at the Columbia Hospital of Richland County in Columbia. Dr. Rentz is a member of Phi Rho Sigma Medical Fraternity, Alpha Omega Alpha Honorary Medical Fraternity and Blue Key Honorary Leadership Fraternity.

Dr. Richard Y. Wescoat, Lancaster physician, is Lancaster's "Young Man of the Year" for 1957.

Dr. Wescoat received the coveted award at the annual Jaycees' Man of the Year and Ladies Night Banquet at the Lancaster Golf Club on January 30. Approximately 150 persons, including several distinguished guests were present to see State Representative Albert Watson of Columbia make the presentation.

The South Atlantic Association of Obstetricians and Gynecologists held its 20th annual meeting February 1-5 at Hollywood, Florida. Dr. Manly Hutchinson of Columbia was presiding and Dr. Lawrence Hester of Charleston acted as secretary-treasurer. There are a number of South Carolinians who are members of this association and they hold several offices. Dr. John Fleming of Spartanburg and Dr. Lawrence Hester of Charleston are members of the executive committee. Dr. Fleming is also chairman of the state committee and Dr. Heyward Fonché of Columbia and Dr. G. F. Wilson serve with him. Dr. Arthur Rivers is a member of the American Committee on Maternal Welfare.

A clinical session of the National Committee on Trauma—American College of Surgeons was held in Baruch Auditorium, The Medical College of South Carolina on February 7, 1958.

Presiding—Peter B. Wright, M. D., F.A.C.S., Orlando, Fla.

A program was given by local surgeons—viz—Drs. John Brown, Louie B. Jenkins, Edward F. Parker, William H. Prioleau, Robert M. Paulling, Kenneth M. Lynch, Jr., John A. Siegling, F. E. Kredel, and Luther C. Martin.

ANNOUNCEMENTS

THE GREENVILLE POST-GRADUATE SEMINAR

APRIL 1, 2, 3, 1958

**To be held at Greenville General Hospital
Sponsored by the General Practice Division
Initial Program**

Tuesday, April 1, 1958

8:30 - 9:00 a. m.

Address of Welcome

Dr. Homer Eargle, President, SCAGP

Dr. Everett Poole, President, Greenville County Medical Society

Dr. Horace Whitworth, President, Greenville General Hospital Medical Staff

9:00 - 10:00 a. m.

Common Sense Approach to the Diagnosis and Treatment of Anemias—Dr. Edgar Hull

10:00 - 11:00 a. m.

Treatment of Congestive Heart Failure—Dr. E. S. Orgain

11:00 - 1:00 p. m.

Presentation of Cases from Wards of Greenville General Hospital—Dr. Edgar Hull, Dr. E. S. Orgain, Dr. Peter C. Gazes, and Dr. B. R. Gendel.

1:00 - 2:30 p. m.

Luncheon

Drug Therapy of Hypertension—Dr. E. S. Orgain

2:30 - 3:30 p. m.

Hemorrhagic Diseases—Dr. B. R. Gendel.

3:30 - 4:30 p. m.

Recent Advances in Treatment of Fractures—Dr. John A. Siegling.

7:00 p. m.

Ladies Night—Poinsett Club

Wednesday, April 2, 1958

9:00 - 10:00 a. m.

Recognition of Cardiac Arrhythmias with the Ear and Finger and Remarks on Their Treatment—Dr. Edgar Hull.

10:00 - 11:00 a. m.

Iron Deficiency Anemias—Dr. B. R. Gendel.

11:00 - 1:00 p. m.

Treatment of Asthma with Particular Reference to Status Asthmaticus—Dr. Claude Frazier

Hyper-lipemia and Hyper-cholesterolemia—Dr. Edwin Boyle.

1:00 - 2:30 p. m.

Luncheon

Low Fat, Low Cholesterol Diet—Dr. Edwin Boyle.

2:30 - 3:30 p. m.

CPC—Dr. Jack Norris, Dr. Edgar Hull, Dr. B. R. Gendel, and Dr. Peter C. Cazes.

7:00 p. m.

Banquet—Country Club

The Physician 1958—Dr. Jack Norris

Thursday, April 3, 1958

9:00 - 10:00 a. m.

Chemotherapy of Leukemia and Lymphoma—Dr. B. R. Gendel

10:00 - 11:00 a. m.

Fluid Balance, especially as related to ECG and electrolytes—Dr. Arthur Williams.

11:00 - 1:00 p. m.

Ward Rounds, Greenville General Hospital—Dr. Edgar Hull, Dr. B. R. Gendel, Dr. Peter Cazes and Dr. F. E. Kredel.

1:00 - 2:30 p. m.

Early Detection of Cancer—Dr. F. E. Kredel.

2:30 - 3:30 p. m.

Dr. John Cuttino

3:30 - 4:30 p. m.

CPC—Dr. John Cuttino, Dr. Edgar Hull, Dr. B. R. Gendel, Dr. Peter C. Cazes, and Dr. F. E. Kredel.

PAN AMERICAN MEDICAL WOMEN'S
ALLIANCE TO MEET IN MIAMI, FLORIDA,
APRIL 14-17, 1958

The VI Congress of the Pan-American Medical Women's Alliance will be held in Miami, Florida, April 14 - 17, 1958. Headquarters will be the Hotel McAllister. Women physicians of the United States and Canada are cordially invited to become members and attend the Congresses that are held every two years alternately in North and South America. Delegates are expected to represent the medical women of most of the Latin-American Republics. The scientific program is translated into both languages and deals with medical problems of mutual interest.

Two post-congress trips are being planned. One is to the Caribbean area where some of the member groups will be visited. The other is to Washington, D. C. where the hospitality of the Pan-American Union and the various Latin-American organizations is being offered. The Latin American Music Festival also is being held in Washington at this time.

The Fifty-seventh annual meeting of the Medical Library Association will be held in Rochester, Minnesota from June 2 through June 6, 1958 with headquarters at the Hotel Kahler. The theme of the Rochester meeting will be "Advances in Medical Library Practice". Mr. Thomas E. Keys, Librarian of the Mayo Clinic is Convention Chairman and letters of inquiry should be addressed to him.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The 36th annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held August 24-29, 1958 inclusive, at The Bellevue Stratford Hotel, Philadelphia.

Scientific and clinical sessions will be given August 25, 26, 27, 28, and 29. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

Full information may be obtained by writing to the Executive Secretary, Dortha C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

The Ninth Annual Symposium on Recent Advances in the Study of Venereal Diseases will be held on May 12 and 13 in the Sheraton Hotel, Philadelphia, Pa. The sessions will be open to all interested physicians and to workers in allied fields.

This Symposium will precede a two-day Venereal Disease Seminar for public health personnel of the Northeastern States beginning May 14, which you may also wish to attend.

FELLOWSHIPS FOR TISSUE CULTURE COURSE

The National Foundation for Infantile Paralysis is again offering fellowships to postdoctoral investigators, teachers, graduate students and experienced laboratory personnel with the baccalaureate degree for participation in short courses in tissue culture.

Fellowships may be used for study only in formal courses designed to teach the principles, techniques, and application of tissue culture. Funds will be awarded for the period necessary to complete the course, which, in most instances, is not expected to exceed six weeks.

INTERNATIONAL COLLEGE OF SURGEONS

The 11th biennial International Congress of the International College of Surgeons will be held in conjunction with the 23rd annual Congress of the United States and Canadian Sections (North American Federation) in Los Angeles, March 9-14.

An innovation of the meeting will be a surgical emergencies panel to which members of the American Academy of General Practice are invited. Dr. Ross T. McIntire of Chicago, executive director of the International College of Surgeons and former surgeon general of the U. S. Navy, will be the moderator.

The Cill Memorial Eye, Ear and Throat Hospital, Roanoke, Virginia announces to the profession the program of the Thirty-First Annual Spring Congress in Ophthalmology, Otolaryngology and allied specialties. The meeting will be held April 14 through April 19, 1958, at the Patrick Henry Hotel, Roanoke, Virginia.

The object of the program is to give in a brief

period of time, a series of lectures and demonstrations on subjects of interest to all practitioners of ophthalmology and otolaryngology. It is not intended to prepare men for the practice of the specialties, but to give those who are prepared and are in practice a new impetus for further study and investigation and to offer all in attendance the benefits of the experience of others in the fields covered. The subjects will be presented by men of national and international reputation who possess the highest academic standing, together with a practical background of private and clinical practice. It is our purpose to make this annual program intensely practical and at the same time to maintain the highest standards that are essential for the successful presentation of scientific subjects. In the short time of one week, there is not an opportunity for research or theoretical discussion, therefore, the recent advances and accepted methods of treatment in these specialties will be presented by means of clinical lectures, lantern slides, motion pictures and surgical demonstrations.

DEATHS

DR. FRANK BOLD

Dr. Bold, a physician for more than 40 years, died January 27 in Charleston.

He had served as a city alderman and food health inspector in the early 1920s. He was a 1909 graduate of the Medical College of South Carolina and a World War I veteran. He was a member of the local, state and national medical associations. Dr. Bold was a native of Savannah. He retired from medical practice several years ago because of failing health.

DR. J. N. WEBB

Dr. Jeff Newton Webb, Seneca physician, died at a Seneca hospital December 10 following a brief illness.

Although suffering from a heart condition for some time, Dr. Webb had been in his office and visited his patients as usual up until the time he was stricken. He had seen two patients earlier in the day.

Dr. Webb attended Clemson College, graduated from Emory School of Medicine and served his internship at Westchester Hospital, Philadelphia.

He first began his practice in Townville and following service as a major in the medical corps in France during World War I, returned there and continued his work.

Dr. Webb came to Seneca some 26 years ago to establish what became an extensive practice throughout the area. Few there were who did not recognize the figure of the cigar-smoking doctor.

He was a member of the Seneca American Legion Post, and the Masonic Lodge. He was also a Shriner

and a member of the South Carolina Medical Association and the Oconee County Medical Society



DR. F. B. JOHNSON

Dr. Francis Johnson, well known to many physicians over the state as a teacher of clinical pathology at The Medical College of South Carolina, died on January 16, 1958.

Born January 17, 1881, in Charleston, he attended the High School of Charleston

and the College of Charleston. He received his doctorate in medicine from the Medical College of South Carolina in 1903. He interned at St. Francis Hospital and took post-graduate work in clinical pathology at various New York medical centers, the Mayo Clinic and in Vienna, Chicago and Boston.

He served as surgical assistant to Dr. R. S. Catheart before becoming associated with the teaching staff of the Medical College of South Carolina in 1908. In 1909 he was named director of the college's clinical pathology laboratory and professor of clinical pathology in 1914. He retained both positions until his retirement July 1, 1946.

He was a member of the Medical Society of South Carolina, of which he was a past president; South Carolina Medical Association; Charleston County Medical Society; American College of Physicians; American Society of Clinical Pathologists; American Medical Association; American Society of Tropical Medicine and the Southern Medical Association. He also was a member and past president of the Tri-State Medical Association and was a member of the South Carolina Society and the Huguenot Society and of St. Philip's Protestant Episcopal Church. Dr. Johnson served with the Charleston Light Dragoons on the Mexican Border

DR. Y. M. HYER

Dr. Yeadon M. Hyer, 50, died in a Florence hospital January 29 after a brief illness.

Dr. Hyer was born in Charleston March 28, 1907. He attended the public schools of Charleston, Gaud School, and graduated from Washington and Lee University and the Medical College of South Carolina, the latter in 1933.

He was affiliated with the Charleston County Health Department for several years. A veteran of World War II, Dr. Hyer served with the U. S. Army Medical Corps and was separated with the rank of major.

MORE NEWS

Dr. W. Atmar Smith was re-elected president of the Society for Relief of Families of Deceased and Disabled Members of the Medical Profession of South Carolina at its annual meeting in Charleston.

Dr. F. G. Cain was re-elected vice president. Other officers are Dr. A. G. Buist, treasurer, and Dr. J. I. Waring, secretary.

Dr. Robert Wilson was re-elected to the society's standing committee. Steward for the annual meeting was Dr. R. M. Hope.

Dr. Archibald J. Buist, Jr. was re-elected chairman of the Roper Hospital board of commissioners for the 10th successive year.

Dr. Edward F. Parker was re-elected vice chairman and Dr. R. W. Hanckel, Jr. was elected secretary to succeed Dr. J. A. Siegling who has resigned after serving on the board for the last 10 years.

Dr. Henry C. Robertson, Jr. succeeds Dr. Siegling as a member of the board of commissioners.

The board then re-elected C. A. Robb as hospital administrator and H. R. Everett as assistant administrator and accountant.

Miss Meyeral Engelberg was re-elected director of nursing personnel at Roper.

The Coastal Medical Society, Dr. Sol Neidick, of Beaufort, president, held a ladies' night supper and meeting at the Walterboro Country Club January 16.

Thirty members and wives attended the social hour, which was followed by a panel discussion on "Cancer of the Breast".

Members on the panel were Dr. H. R. Pratt-Thomas, Dr. Harold Pettit, Dr. John Hawk and Dr. Carter Maguire, all of Charleston.

Following the scientific part of the program a steak dinner was served.

DR. VINCENT RE-ELECTED IN LAURENS

Dr. C. P. Vincent has been re-elected county physician and Dr. J. F. Dusenberry as assistant county physician.

Dr. F. R. Fleming, specialist in eye, ear, nose and throat, has moved to Myrtle Beach and has opened offices at 206 76th Avenue North.

Dr. Fleming moved from Georgetown, where he spent three years. Prior to that time he was at the Hugh Chatham Memorial Hospital in Elkin, N. C., in eye, ear, nose and throat work, and a year at the Newark, N. J., Eye and Ear infirmary. He spent five years as a flight surgeon in the United States Air Force.

The newly arrived physician received his A. B. de-

gree at the University of North Carolina; his B. S. in Medicine at Wake Forest; and his M. D. at Jefferson Medical College of Philadelphia, Pa. He received a graduate course in ophthalmology at Harvard University.

Dr. Fleming, a native of Hamptonville, N. C., is a Diplomate of the American Board of Ophthalmology; member of the American Academy of Ophthalmology and Otolaryngology; member of the S. C. Medical Association and the American Medical Association.

Dr. Blanchard Fred Ford, Jr., has begun general practice at Ocean Drive Beach and is now located in the new doctors' building at Oak Drive and Second Avenue.

Dr. Ford received his education at the University of South Carolina and graduated from the Medical College of South Carolina, Charleston, in 1938. He interned at Roper Hospital and was later resident physician at McLeod Infirmary in Florence. As a lieutenant commander, Ford spent four and one-half years in the Navy Medical Corps, serving on APAH duty in Hawaii and Sub-Chaser Training Center Dispensary on Saipan. He also served at the Key West Naval Hospital and the Norfolk Naval Hospital. He practiced at Maxton-Laurinburg, N. C. for 11 years and was chief of staff of the Scotland County Memorial Hospital, where he was president of the Scotland County Medical Society of 1954-55.

DR. JOHN M. PRATT HEADS HOSPITAL MEDICAL STAFF

Dr. John M. Pratt was named head of the Medical Staff of Divine Saviour Hospital at the regular monthly meeting held at the hospital.

Dr. E. A. Perry of Clover was named vice-president and Dr. Philip Claytor is the new secretary.

The South Carolina Radiological Society met February 1, at the Columbia Hotel.

The Saturday meeting opened with a luncheon at one o'clock in honor of Dr. and Mrs. Charles Bream. Dr. Bream is a member of the Radiological Faculty of the University of North Carolina, and spoke at the scientific session on "Radiologic Exploration of the Retro-peritoneal Space."

Dr. Ralph Hubert Bowick, a medical practitioner and general surgeon, has established offices at 201 S. Pendleton St., Easley.

The 32-year-old physician is a native of McCormick County and has been living here for a short time.

A graduate of Clemson College, Dr. Bowick was in military service from 1944 to 1946 and received his M. D. Degree from the Medical College of S. C. in 1951.

He served an internship at the Wayne County General Hospital at Eloise, Mich., from July 1951 to

June 1952.

The new Easley physician was a general practitioner for six months in McCormick, and served a surgical residency at Wayne State University Program at the Detroit Receiving Hospital and Dearborn Veterans Hospital from January 1953 to June 1957.

DR. E. FINGER NAMED PRESIDENT

Dr. Elliott Finger of Marion was elected president of the Pee Dee Medical Association and delegate to the state convention during the monthly meeting at Pee Dee Lodge. Dr. Randy Elvington of Nichols was elected vice president and Dr. J. B. Berry, Marion, secretary and treasurer. Dr. H. S. Gilmore of Nichols was named alternate convention delegate.

JAYCEES HONOR DR. YOUNG

The "Distinguished Service" award to the outstanding young man of Hampton-Varnville was presented to Dr. Walter L. Young, for his contribution to the community in the Red Cross Blood Bank program.

HEART GROUP'S 1958 MEETING

The ninth annual meeting of the South Carolina Heart Association was on February 3 in Greenville.

Dr. A. Izard Josey of Columbia, president of the association led the meeting.

Among speakers for the one-day session were Dr. E. S. Cardwell, Jr., pathologist, Columbia Hospital, and consultant pathologist, Veterans Administration Hospital.

The officers, other than Dr. Josey, are Dr. George R. Wilkinson of Greenville, vice president, H. M. McElveen, Columbia, executive director, and Burnell Sloan, Columbia, treasurer.

Dr. Kelly McKee, Charleston, was elected secretary of the Section on Medicine at the recent annual meeting of the Southern Medical Association.

Dr. Edward F. Parker of Charleston attended the three-day sectional meeting of the American College of Surgeons in Jackson, Miss., January 16 through 18.

Topics discussed by leading surgeons of the society included treatment of accident injuries, burns, heart and lung surgery, pediatric surgery, cancer, ovarian tumors, transfusions and other problems of current concern.

Dr. Parker participated in a panel discussion "New Horizons in Cardiac and Lung Surgery."

THE MONTH IN WASHINGTON

Washington, D. C.—Those who are trying to follow the course of medical legislation, find an unusual situation developing in this session of Congress. All of Washington is being subjected to forces, some completely new, that often work at cross-purposes to each

other. The result could be a moratorium on health legislation—or again it could be a flood of new laws.

At the start of the session, a new-born interest in science completely dominated the scene—by a frantic spending of billions of dollars we would overtake Russia. That was the theme in Washington, and it persisted despite a few quiet voices that asked whether Russia really had far outdistanced the U. S. or was merely exploiting a slight advantage.

Even before the American satellite started on its orbit, some of the panic had subsided, and most of the legislators had decided that advent of the space age had not removed all of the old problems and opportunities in legislation and politics. The familiar issues were still there, medical panaceas included.

The shock of Russian achievements will, at any rate, produce legislation designed to shore up our educational system. This seems to be generally accepted. For the medical profession, two provisions are of major interest. Scholarships would be either four years—possibly six—offering some assistance to premed students and in some cases to those in their first year of medical school. Also, fellowships would be available for medical and other graduates if they wanted to teach or go into research.

The administration's idea was a program that would cost a billion dollars; several leading Democrats joined in a bill proposing three billion dollars as a stimulant to mathematics and science.

But there are other factors to be reckoned with. For the first time a President set down in black and white in his budget just how he proposed to withdraw the federal government from some activities, or limit its participation, and turn the programs back to the states. Mr. Eisenhower wants to slow down on the Hill-Burton hospital construction program and change its emphasis, he wants to mesh in some veterans' benefits with social security payments, he would have the states do more and the U. S. less in public assistance (where medical payments are a growing factor), and he hopes to get Congress to drop the \$50 million a year program of grants to help build water treatment plants.

Whether Congress will follow the President's lead in the back-to-the-states movement is another question. At least he has said specifically what he thinks should be done, and when.

There was no expectation that the Russian scare would dilute politics this election year—and it hasn't. If anything, the partisans are struggling harder than ever to make records that will reflect glory on them next November. Some of course, would be pressing for their projects regardless of the election.

So this is the prospect, in brief:

The Defense Department and science will get the major attention and the major money, but some may slip over into medicine.

There is some interest in a tight domestic budget

and returning certain activities to the states, but old fashioned politics combined with a fear of a continuing recession may again open up the federal purse.

Medical legislation, always a popular subject, may get more and more attention as the session rolls on. If so, the Forand bill among others would come immediately to the fore.

NOTES:

Several developments in the legislative field on Jenkins-Keogh bills came early in the session. The American Thrift Assembly, representing some 10 million self-employed, urged favorable House Ways and Means action, and the American Medical Association pointed out that the proposal for tax deferment of money paid into retirement plans could help solve the problem of maldistribution of physicians.

In the Senate, a majority of the Small Business Committee introduced a tax relief bill with a J-K provision. The section would allow anyone not now benefitting from a qualified pension plan to set aside 10% of annual income (\$1,000, maximum). The bill went to Senate Finance Committee.

BOOK REVIEWS

INTRODUCTION TO ANESTHESIA by Drs. Robert D. Dripps, James E. Eckenhoff, and Leroy D. Vandam. W. B. Saunders Co., Philadelphia, 1957. Price \$4.75.

The authors of this book have had extensive experience in teaching anesthesiology to students and residents at the University of Pennsylvania Medical School and at the Harvard Medical School. They have written an up-to-date appraisal of various anesthetic drugs and have described safe, effective, clinical methods for the use of inhalation, regional, and intravenous anesthesia. Certain specialized techniques and the minute details of seldom-employed anesthetic procedures properly have been omitted from this book, since its primary objective is to present principles of the safe practice of anesthesiology in the simplest and clearest manner suitable for the instruction of medical students and beginning anesthesiology residents.

The book is divided into four sections: the pre-anesthetic period, the day of anesthesia, during operation, and the post-operative period. This logical framework contains information on such vital topics as relationship between the surgeon and anesthesiologist and relationship between the patient and anesthesiologist. Certainly these sections on the art of the practice of this specialty are a welcomed addition to the extremely well-documented portions of the book on the science of the practice of anesthesiology.

John M. Brown, M. D.

PHYSICIAN'S FEDERAL INCOME TAX GUIDE, 1958 EDITION, by Hugh Campbell and James B. Liberman. Edited by Henry D. Shereff. Channel Press, Great Neck, N. Y. Price: \$2.50.

This is the twelfth annual edition of a tax guide that has been used by a great many of the practicing physicians in the nation. This is a book of 100 pages which is compiled for detailed and ready reference. It would seem to be capable of supplying the answer to any question on income tax which the harassed tax payer might want answered.

The Guide is available from Channel Press, 159 Northern Boulevard, Great Neck, New York, for \$2.50. It is also available in leading bookstores.

WILLIAM HARVEY: His Life and Times, His Discoveries, His Methods, by Louis Chauvois. The Philosophical Library, Inc. New York, 1957. Price \$7.50.

Dr. Chauvois begins his biography of Harvey in 1627 at the height of his powers, physician to Charles First, sought after by the most illustrious of his contemporaries, Lumleian lecturer of the College of Physicians, general practitioner of medicine, physician in chief of St. Bartholomews Hospital and, with what spare time he had, investigator of the circulation of the blood.

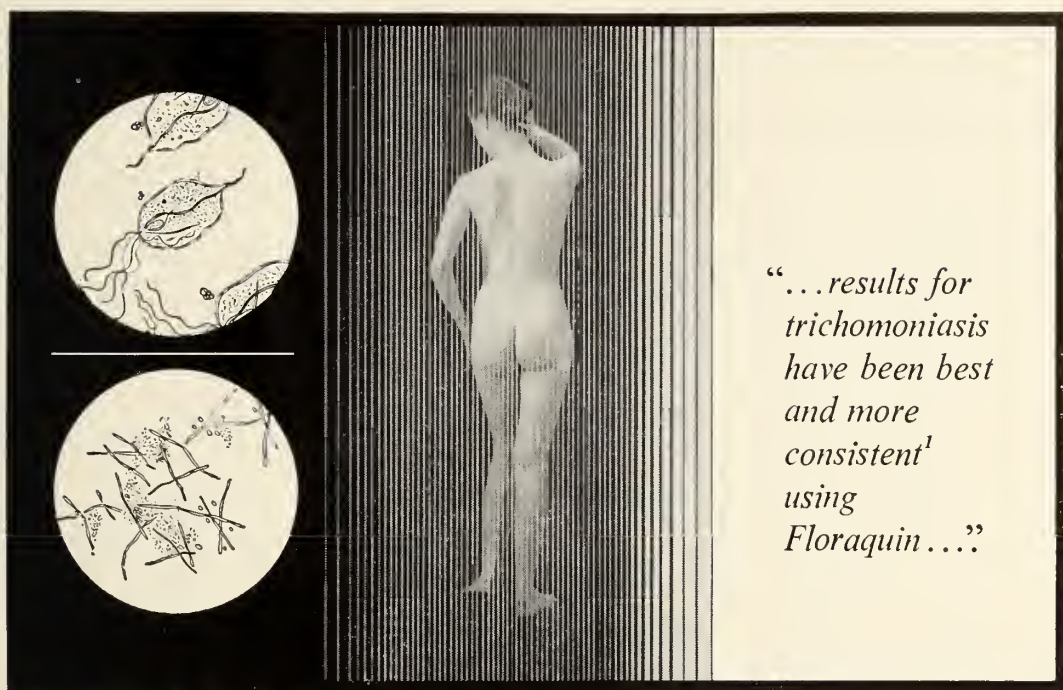
"Here he is on the threshold of his house, his head uncovered, and dangling from his right hand is a large, broad-brimmed hat. A cape is draped over his left arm. He is a small man . . . His face is spare and high in colour, though his skin is so dark as to be almost olive . . . The thick black hair of his head recedes from a lofty and broad forehead beneath which were two dark eyes, lively and penetrating. Some habit, it may be of spiritual tension, raised the left eyebrow above the right . . .

"After a few minutes wait (for his carriage), the little man, obviously impatient, puts on his hat and flings his cape over his shoulders . . . He walks down the roadway and takes the path—so often trodden—that leads him to his daily goal, St. Bartholomews Hospital . . . He moves rapidly, carried along by supple and muscular legs that never seem to tire . . ."

If stopped by an acquaintance, "He would finger the little dagger that since his Padua days he always wore at his side. He would unsheathe it and then would place the point or the flat side in the palm or on the back of his hand, as though better to support his arguments for the principle of the circulation of the blood which the ignorant and willfully obstinate would still not accept."

After an intimate personal portrait, Chauvois describes the molding of Harvey as a boy. He attended King's grammar school at Canterbury. Here, tempered by the practice of physical exercises and of sports, Harvey acquired the physical vigor which would later allow him to meet the insistent demands of his scientific and professional pursuits.

While he was here, in 1588, the Armada of Phillip II was repelled and Harvey's holiday visits home to Folkstone must have been exciting ones as he watched the small English vessels prepare to destroy the



Floraquin[®] eliminates trichomonal and mycotic infection; restores normal vaginal acidity

Leukorrhea is by far the most frequent symptom of vaginitis; trichomonads and monilia are the most common causes. Many authors have reported² trichomonal protozoa in the vagina of 25 per cent of obstetric and gynecologic patients. Increased use of broad spectrum antibiotics has resulted in a sharp rise in the incidence of monilial infections.

Floraquin effectively eradicates both trichomonal and monilial vaginal infections through the action of its Diodoquin[®] content. Floraquin also furnishes boric acid and sugar to restore the normal vaginal acidity which inhibits patho-

gens and favors the growth of protective Döderlein bacilli.

Pitt¹ recommends vaginal insufflation of Floraquin powder daily for three to five days, followed by acid douches and the daily insertion of Floraquin vaginal tablets throughout one or two menstrual cycles. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

1. Pitt, M. B.: Leukorrhea. Causes and Management, J. M. A. Alabama 25:182 (Feb.) 1956.

2. Parker, R. T.; Jones, C. P., and Thomas, W. L.: Pruritus Vulvae, North Carolina M. J. 16:570 (Dec.) 1955.

SEARLE

Spanish fleet. These years left Harvey with the feeling that, as an Englishman, he was a person of some importance. When he left England for study in Padua he impressed all newcomers not only with his well-stocked brain but also his juvenile authority.

He was led to Padua by Dr. Keys (latinized to Caius) while a student at Cambridge's Gonville-Caius college, and at Padua listened to Galileo, Colombo and Caesalpinus. Harvey was much at home amidst the liberal thought here and certainly heard the beginnings of his concept of the circulation as the philosophy of his teachers. His professor Fabricius taught him much as he demonstrated the valves of the veins.

Not long after his return to London he was made the Lumlein lecturer of the College of Physicians. His notes for these lectures, handwritten on both sides of sheets of foolscap and kept in a leather case tied with ribbon, are almost illegible because of the poor handwriting of the doctor and his habit of writing in both Latin and English and using abbreviations freely.

It was in these lectures given to the practitioners of London that Harvey's methods and concepts unfolded. His magnificent "Exercitatio Anatomica De Motu Cordis et Sanguinis in Animalibus" was not published until 1628 when he felt that his animal experimentation was sufficient to confirm his thesis.

The activities of the physician during these most productive years were multitudinous. He sustained himself with coffee which his brothers imported from Turkey as he lived out his life as a writer, lecturer, physician, scientist and politician trapped as a king's man when Oliver Cromwell revolted.

Dr. Chauvois portrays in scholarly detail the life and the fascinating era of Harvey. Shakespeare presented his plays a few blocks from Harvey's home and Francis Bacon was his patient. He disliked Bacon because the man was a philosopher, not an experimenter. Perhaps Dr. Harvey gained some respect when Bacon caught his death of pneumonia while stuffing a chicken with snow to see if he might preserve it.

An interesting chapter of his book is devoted to the judgment of the man by his contemporaries and posterity. Descartes, for instance, was in part most critical and his criticism is reviewed.

This book, with much charm, wit and affection for

the subject, reviews Harvey's publications in detail.

It is appropriate that it be published in this, the three hundredth anniversary of the death of William Harvey.

Arthur V. Williams, M. D.

SCHIZOPHRENIA IN PSYCHOANALYTICAL OFFICE PRACTICE. 30 contributors. Edited by Alfred H. Rifkin, M. D. Grune & Stratton, New York, 1957. Price \$4.00.

The combined thinking of 30 outstanding contributors, amassed in only 145 pages, has made this book one of the best monographs concerning the understanding of schizophrenia. Although at first glance it appears to be a very technical book on the psychoanalytic treatment of schizophrenia, it really is much more than that. I have not seen or read any book that more clearly describes in relatively brief form, the scope, tone and clinical form of schizophrenia. The general tenor of the book is bold in that, "schizophrenia is not a disease—it is a pervasive disturbance in a way of living, in a way of looking at the world, in a way of interacting with it." Mystical or magical thinking, transcendence or omnipotence (personal independence from natural law) and an intense preoccupation with one's inner emotional life characterize all schizophrenias—these are the basic symptoms.

This book, immensely readable, clearly injects therapeutic optimism into the vast problem of this condition. There is liberal referral to Manfred Bleuler, son of Eugen Bleuler, the Swiss psychiatrist who first described and named this condition at the turn of the twentieth century. The son, internationally known on his own merits, has been one of the forces responsible for re-centering interest in the psychotherapeutic management of the schizophrenic. The 30 contributors, all outstanding American psychiatrists, have clearly demonstrated that schizophrenic language, thought and behavior makes psychological sense once the therapist can appreciate the unique sensitivity that characterizes a schizophrenic.

This book should interest all those interested in mental health since it expresses therapeutic optimism, not grandiose claims for the most distressing of all human problems.

Norton L. Williams, M. D.



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TREATMENT OF FUNCTIONAL ILLNESS BY THE FAMILY PHYSICIAN

JOSEPH HUGHES, M. D.

Clinical surveys have shown that fifty to seventy percent of patients consulting physicians do so because of functional illness. This paper has as its purpose the stimulation of the interest of the general practitioner in the treatment of the emotional as well as the somatic factors that lie behind functional disease. To achieve this purpose it is proposed to consider the etiology of functional illness primarily in terms of its psychogenic aspects and to indicate ways and means by which the general practitioner might increase his own psychiatric insights and psychotherapeutic skills in the treatment of these conditions.

Three general theories have been developed by physiology to explain bodily reactions to stress situations. The first of these theories was Cannon's concept of homeostasis.¹ The second was Pavlov's theory of conditioned reflexes.² The third, and current theory, is Selye's adaptation theory.³ These theories emphasize physiological reactions and do not consider the psychogenic factors involved in functional conflict situations such as repressed memories, feeling states, cultural conditioning and competitive striving.

Investigators in the field of experimental psychiatry have obtained evidence of relation-

ship between feeling states and bodily reactions. There is evidence to show that hostility gives rise to increased muscle tension and that high muscular tension is associated with depressed states.⁴ There is also data to show that fear results in hypofunction of the gastrointestinal tract and that sustained resentment can result in hyperfunction.⁵ Other investigators have related that emotional deprivation in childhood, unhealthy mother-child relationships, rejection and deteriorating life situations lead to the development of a number of psychosomatic disorders including peptic ulcer,⁶ ulcerative colitis,^{7,8} thyrotoxicosis,⁹ and asthma.¹⁰ As a corollary, it should be mentioned that similar psychogenic factors are found associated with psychiatric illness. Because of this relationship, the hypothesis could be made that if psychogenic factors could be relieved or ameliorated by early treatment in the life of the individual by the family physician, using both his medical and community's social resources, the incidence of psychiatric illness could be decreased.

There have been five psychiatric theories developed over the past twentyfive years to explain the etiology of functional illness. The first was the conversion theory (Ferenczi¹¹) which held that the patient's somatic symptoms symbolized repressed, unconscious feelings; the second was the theory of personality profile (Dunbar¹²), which held that the personality type of the patient determined the nature of the functional symptoms; the third

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was the theory of specific conflict (Alexander¹³), which held that a specific type of conflict situation always gave rise to a specific type of psychosomatic reaction; the fourth theory was the protective adaptive reaction (Wolff¹⁴), which holds that psychosomatic symptoms resulted from faulty adaptation to stress; the fifth theory was the one of physiological regression (Michaels¹⁵), which holds that psychosomatic symptoms resulted because of regression to infantile patterns of reaction to stress.

At the present time there is general agreement among investigators interested in the problem of the etiology of functional illness that these illnesses develop out of multiple non-specific conflict and stress situations in the life experiences of the patient. Furthermore, there is agreement that for a functional illness to develop it is necessary to exhaust the adaptive mechanisms of the mind and body.

Clinical evidence indicates that susceptibility to functional illness is greater among patients whose character structure is rigid and unyielding as compared to those whose personality reactions are more flexible. There is also clinical evidence to show that insecure and discordant family relationships, broken homes, emotional deprivation and socio-economic distress in childhood lower a patient's threshold for functional illness later in his life. It should be remembered that patients differ in their sensitivity and susceptibility to conflict situations, just as they differ in their character and personality structure. This difference is one of the reasons why apparently comparable conflict situations may be destructive to one patient's ego and leave another's unscathed. In this regard it is important to keep in mind that it is not the conflict situation, as such, but its meaning to the patient, either objectively, subjectively or symbolically, that determines whether it can or cannot be a threat to his ego and to his emotional health.

Since a purpose of this paper is to encourage the general practitioner to increase his psychiatric insight and to add to his own skills in psychotherapy, a simplified classification of conflict situations and of psychopathological reactions seen in patients in practice has been

prepared with the hope that the individual physician reading this paper might find these classifications useful in the analysis of his own patients' disturbed emotions, and that these simplified classifications might make for more meaningful psychotherapeutic doctor-patient relationships in his practice.

For purposes of use in the family physician's daily practice, conflict situations may be classified into three general categories:

1. Conflicts growing out of difficulties in interpersonal relationships.
2. Conflicts arising because of the existence, in the mind of the patient, of unacceptable aggressive or sexual drives.
3. Conflicts that arise out of competitive strivings for life goals that are beyond the patient's capacity to achieve.

The psychopathology that lies behind a patient's disturbed emotions or faulty habit patterns of feeling and thinking may be identified as falling into four general categories of reactions:

1. Repression of resentment and hostility because of guilt feelings or fear of retaliation.
2. Projection of hostility to others because of instinctual drives that are unacceptable to the patient's ego because of the character of his own conscience or because of fear of social disapproval.
3. Ambivalent attitudes (love and hate) towards a key figure in the life of the patient (parent, loved one, boss or superior) associated with feelings of guilt, hostility or fear.
4. Denial of the need for affection associated with feelings of rejection, abandonment or fear of destruction of one's ego.

Effective psychotherapy is dependent, not only on skills for analyzing conflict situations and on skills for identifying and recognizing psychopathological trends, but on skills in the use of interviewing techniques. When a physician has developed a good technique for interviewing a patient it may be measured by his capacity to listen in a friendly, accepting way to what the patient has to say and by the physician's capacity to make a patient feel comfortable while he is discussing his problem. Interview skill is the only basis for the establishment of a good doctor-patient relationship. One of the physician's roles in inter-

viewing a patient is to convey by his emotional attitude and by what he says that he has the "WISH TO HELP" his patient. It is to be remembered by everyone interested in psychotherapy that angry and rejecting attitudes can reenforce a patient's fears and lead to a fixation of symptoms, whereas friendliness and an attitude of realistic understanding can set up in the mind of the patient the WISH TO BE HELPED.

If the diagnosis of functional illness is accepted to mean any illness that results from disturbances that are either psychogenic or physiological in origin then it can be expected that functional illness will be seen clinically in every age group from infancy to old age. It is a fact that these illnesses do make up the largest group of patients seen in practice.

As a medical procedure in the examination of a patient with functional illness it is recommended that after the medical history has been taken, a complete social history should be obtained before making the physical examination. The social history should cover the following five points:

1. The patient's attitudes and feelings toward the key figures in his life (parents, siblings, beloved person, bosses or superiors).
2. Goals and ambitions.
3. The nature of the patient's psychological defenses to anxiety (rationalization, repression, denial, substitution, avoidance, withdrawal, submissiveness, hyperactivity, aggressiveness, ambivalence, etc.).
4. Emotional reactions to stress (dominant mood).
5. Conflicts and frustrations.

It is possible for the preliminary social history to be taken by a nurse trained in the art and skill of interviewing.

The best treatment for functional illness is early treatment. This should consist of skillful medical care for the disturbances that are physiological in origin combined with psychotherapy for the disturbances that are psychogenic in origin. The family physician is in the key position to provide for both the somatic and psychotherapeutic needs of the functionally ill patient. The psychiatrist should only be brought in to treat those patients whose symptoms result from the more severe psychogenic

disturbances. To achieve this goal both medicine and psychiatry should team up and pool their techniques and resources so that the functionally ill patient may have the best care and treatment.

In conclusion it may be said that the following seven facts may be helpful in understanding some of the problems of functional illness:

1. Functional illness frequently masks itself in terms of physical symptoms.
2. Everyone has his own threshold for the development of a functional illness. Prompt diagnosis and treatment leads to recovery.
3. Patients are usually unaware of the true nature of their illness and are mistaken in their own analysis of their feelings which may vary from fatigue to uncomfortable bodily feelings or from feelings of guilt, anxiety and depression to loss of confidence in himself. Emotional health may be measured by a sense of well being, the ability to feel comfortable and to get along with others. Emotional illness is characterized by the lack of a sense of well being and the lack of the ability to feel comfortable with one's self and others.
4. It is a distinguishing feature of patients with functional illness to feel threatened by guilt feelings and trapped by frustrations. Such feelings are inherent whenever patients are overwhelmed by insecurity.
5. Patients in their efforts to relieve anxiety and solve their problems will create states of anxiety for their families. It is essential, in dealing with the insecurity of the patient and the family, that there be some area of agreement between the doctor, the family and the patient about the goal of treatment.
6. Factors which can influence the course of a functional illness are: shifting forces in the life of the patient creating conscious and unconscious conflicts and frustrations, unrealistic goals, unobtainable wishes and expectations, uncompromising rigid attitudes, depleted emotional resources and intervention of chance resulting in the development of either favorable or unfavorable circumstances in the life of the patient.

7. The family physician, with skills in psychotherapy, is in the key position to treat patients with functional illnesses. These patients

(Continued on Page 148)

MEDICAL EDUCATION IN SOUTH CAROLINA

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The story of present era medical education in South Carolina must naturally be tinged with personal color if told by me. The present era is the period of state ownership and operation, the forty-five year period from 1913 to 1958. It calls for some reminiscence, a cast up of what has occurred, and for a look into the future so far as the horizon will allow, when I consider that this year brings the forty-fifth anniversary of my arrival in South Carolina as the first employed member of the faculty imported by the new board of trustees elected by the General Assembly.

May I interject here to pay tribute to that Board of Trustees, as I know it in the present and as I have known it for the twenty-three years of my regular attendance at all of its deliberations. Its nature and the calibre of its controlling personnel have been of decisive importance in the maintenance of steadfast policy, always with the interests of South Carolina placed first.

So far as I am aware it is the only medical school board of control in which the dominant influence arises from the viewpoint of the practicing medical profession of the area of relations of the school. It provides the soundest liaison between the school and the medical profession that could be devised; while there is no law requiring that any of its members shall come from the ranks of the profession, by firmly fixed custom that practice is not likely to be changed. Further, it is and always has been composed of a well-balanced representation of the various areas of medical practice, with the factor of general practice uppermost in the thinking. I hope that the nature of this board will never change; I know of many medical institutions where there is envy of our

foresight, or good fortune, whichever it was that brought about our system of control. The medical profession of South Carolina may be assured that the Medical College will protect the interests and the position of the practicing profession as they should be.

My introduction to medical education and to medicine in South Carolina was not designed, unless you can say that the circumstances which come into play controlling the course of probably the majority of our individual lives comprise a design beyond our knowledge and intentions.

When my revered chief at Pennsylvania was asked to recommend someone for the full-time position of professor of pathology and sent me down to look the place over, I visited the little original building of the Medical College. It was an architectural gem, and it should have been preserved as a shrine of medical education in America, of which it represented a pioneer — *the* pioneer of the South. I shed tears when it was later demolished (and a portion of the old jail, nearby, kept as a historic relic) to make room for a New Deal housing project.

In this building there was little that resembled a modern medical school facility, while adjacent to it was a rough frame shed-like structure proposed to accommodate laboratories, but containing no equipment worth mentioning.

When I returned to Philadelphia to report that I could see no opportunity down there, my chief said, "Well you go down there and help them build a medical school and it will help build you." There is deep philosophy in that advice.

While the road between 1913 and 1958 was for a long time bleak, and very rough, even in recent stretches, it has now been broadened into a highway—but modern highways cost

(Presented before the Anderson County Medical Society—January 14, 1958)

money to build and money to keep up. Furthermore, in medicine there is no such thing as leveling off to a standstill. That sets up the danger of the present moment.

While costs of living have advanced alarmingly, medical care costs, affecting medical school operational costs basically, have increased even disproportionately. It is reported that the costs of hospital operation have risen 264% during the short years of the Medical College construction period, for a reason that is very important to everybody—the availability of health and medical care protective and restorative measures and facilities which have increased the span of happier life even beyond the Biblical allowance, and on a plane of safety and comfort hardly imaginable a few years ago.

Although progress in the course of medical education in South Carolina was slow and painful for most of the forty-five years of state control, the last decade has seen advancement which, even by comparison with the field in general, is truly phenomenal.

Within that epoch has been developed a medical educational, research and service center of top-flight calibre. In physical facilities the Medical College has constructed a basic and clinical science building, a men students' residence which is the envy of other institutions and has been emulated by some, a school of nursing building second to none, and a superb hospital—providing every available comfort and service known to medicine.

The opportunity in undergraduate medical education and the consequent supply of doctors have been more than doubled; post-graduate and specialty training has been provided for more than four times any previous number of participants, covering all phases of medical training in a manner equal to any and superior to many; technical training and employment have grown to the proportions of more than a hundred for each one previously accommodated; professional pharmacy attracts ten times as many candidates, and is at capacity; the school of nursing overflowed its physical capacity within a year of occupying its new building, and is now turning away qualified applicants; the new Medical College Hospital is in full swing at the completion of its

second year, and expects to set something of a record by full bed capacity activation in its third year. All told, the Medical College has improved its facilities and the opportunities it provides by a ratio of ten times or more, and in many respects beyond any calculable comparisons.

While most of what this signifies cannot be measured in terms of dollars or any other figure factors, the financial considerations are of course basic.

In the new buildings, and their equipment, in land acquisitions, in internal reconstruction and re-equipment of the old buildings, the Medical College has invested some \$17,000,000, less than a half of which came from state appropriations.

Together with the associated hospitals, both new and old, the medical center comprises an intrinsic investment value of some \$30,000,000 or more, in a campus of about eighty acres. We visualize additions and improvements that will not only have the physical appearance but will accommodate the quality and the philosophy of a true university, although of health and medical leaning and objectives. Such is the conception of the medical educational, research and service center of the future, university organized but in the control of the health and medical professions.

Educational Budget

To carry this operation, the annual budgets are of proportions not easily comprehended. For the ordinary educational operation we required this year about \$1,650,000, more than ten times the budget of fifteen years ago. About a third of this operational cost came from other sources than the state operational appropriation. We have requested the General Assembly to provide for this educational budget for 1958-59 \$1,074,000. The Medical College administration is the only authority in this question, the only factor competent to calculate the costs required. This is not the time to curtail support of this life and health science and service operation. We cannot be excluded from the considerations now being given belatedly to the part that science plays in safety, even in the new crucial question of survival of this nation and of freedom.

For myself, I am convinced that the present

and the immediate future is the most dangerous and the most decisive period in history. While we must entrust to our national leaders the grade of "crash" program necessary to safeguard us in freedom, it does not call for unbalance now. We must keep in mind and purpose the life and happiness sciences as well as the death and destruction sciences.

Incidentally, our educational budget is about one half of a million dollars less than the average of the medical schools over the country, which average has increased from one million to one and a half million in seven years. Also, our budget carries the schools of nursing and pharmacy as well as medicine.

The Medical College Hospital

The other large budget which must be brought into focus and understanding is the separate operational budget of the Medical College Hospital.

This new hospital, designed and operated on model lines, was of course built to provide the clinical facilities and opportunities required for a medical school of front rank. It incidentally serves as a referral hospital for the service of the patients of private practitioners when they need to seek special services that cannot be provided at home. While its staff is limited to the medical faculty, we recognize the primary position of the patient's home physician and give him automatically the title and position of associate attending physician for his case.

No patient is admitted except by bona fide referral of a licensed practitioner in private practice. That principle is strictly enforced; the president receives a daily roster of admissions carrying the name of the referring physician as well as that of the staff member in charge and the name and address of the patient. While the institution is not a charity hospital, no patient pays a professional charge when judged unable. In order to provide a full and varied teaching program, county-supported patients from other areas of the state, as well as a few selected for need in teaching, are sometimes admitted, but only by private physician referral and careful clinic screening. It is interesting to note that last month the patients in the hospital came from forty-one of the forty-six counties in the state, and from

seven states other than South Carolina.

Patients who are able to pay for professional care are charged regular fees, in accordance with a fee bill approved by the staff and the Board of Trustees. These charges are not above Medicare listings in any instance, and in many items, particularly in the laboratory area, are much lower. The president's office assumes the responsibility of scanning all professional charges.

For the full-time staff and for those of the part-time staff who desire, bills are sent by a special section of the business office, but separately from the hospital bill and in the name of the doctor providing the service given. From such collections a handling charge of 8% is deducted and the balance transmitted to the staff members concerned.

Thus is protected the traditional and ethical relations of doctor to patient and doctor to consulting doctor. The institution is not in the practice of medicine, nor can it or the state make a profit from the professional services of its staff. Probably more than is generally done, we have set up rigid safeguards on these fundamental principles.

Since the members of the full-time clinical staff, as well as the basic science faculty, are on a salary basis and are primarily engaged for teaching, there is not only a natural limit to the pay patient care they may undertake but an acknowledged limit to their earning privileges. Incidentally, salaries of strictly basic science faculty members are higher than in the clinical area, although in neither category do they come to the mean of medical school faculties over the country. The fact that we have been able to secure a full-time faculty of top quality (nearly all of the basic science members holding both M. D. and Ph. D. degrees) means that our policies and opportunities are more attractive to such scientists than are the positions they are continuously offered at higher compensation.

It is believed that we have handled the vexatious problem of privilege and at the same time limitation of the earning opportunity of salaried clinical staff members much more agreeably and properly than generally is the case, thereby forestalling deep troubles and conflicts that have occurred elsewhere.

The Board of Trustees has thus far declined to place an arbitrary figure limitation; it has said that such scientists as we require to do the kind of job expected must be able to hold up their heads in select company, and that otherwise we shall not have them. They have said that as long as a faculty member is doing his job well and is not profiting unduly out of his subsidized and select position he must not be shortened in stature by a low ceiling—that an earned income of up to twenty-five per cent less than he might reasonably be expected to earn in another capacity is not to be questioned.

That fine policy places heavy responsibility upon the president's office; except for the auditor (and the tax collector), I am the only person who knows what the earned income of each member of the salaried faculty is. It also places serious responsibility upon the staff members.

Beginning last year a sectional group made an agreement among ourselves that of our medical fees from referral or consultation practice, regardless of amount, we would contribute to the Medical College a certain per cent, the contribution to be made through the American Medical Education Foundation, for the credit and possible augmentation accruing in that route.

Within recent days another group of the staff has come forth with a plan whereby any earnings beyond a certain amount, which figure could hardly be challenged by any informed person, would be returned to the Medical College by the same route of contribution.

Thus the staff of the Medical College is assuming its responsibility in this crucial problem voluntarily by a self imposed ceiling. I have been invited to discuss this developing plan at a conference of the AMEF to be held shortly, and, even though I could not accept, on account of other committed engagement, the Medical College of South Carolina plan will be discussed there, in hopes that it may spread.

These major principles of organization and operation of the new teaching, research and service hospital are recited in some detail because they answer the questions in mind on

how we have carried out our commitment to the profession as well as to the public of South Carolina.

In its first full calendar year of operation the hospital revenues took care of 22% of the cost, in the second year 35%, and we expect the third year to make it more than 40%, which I believe will establish another record. In discussions through the years with the General Assembly, whenever I have been pressed with the question, I have always tried not to mislead, and I have repeatedly said that by the experience of others and by such calculations as we can make sensibly, the eventual net cost to South Carolina of this hospital operation is expected to be from a million to a million and a half. For 1958-59 we have asked for an appropriation of \$1,500,000, the same as this year, to which we expect to add \$960,000 of hospital revenues. In addition to our own dependable cost calculations, perhaps it is fair to draw comparisons for reassurance. The annual budget of a county hospital in South Carolina of the same bed capacity is of approximately the same total, and a county of this state appropriates over a half million dollars just for the hospital care of its indigent sick. Other comparisons could be drawn to exhibit that our budget is quite economical, by no means extravagant or even as high as many other comparable hospitals.

Research

Any review of the activities of the Medical College would be incomplete without noting the importance and volume of research. Although a few of us have knitted along on our urges and ambitions—and entirely at our personal expense—from the beginning, it is only during the recent decade or so that one could say that the spirit and effort of the research upon which our health and happiness progress rests pervades the institution. From fundamental research in physiology, chemistry, genetics, microbiology, through major accomplishments in cancer and in heart and vascular disease to important advances in surgical and other techniques, a recitation of all of which would occupy more of an address by itself than this effort has been.

Neither now nor heretofore has this important work, essential in a medical school

program, been supported by state appropriation. The expenses, already past the half million mark annually, we have had to find elsewhere, from large industrial organizations and companies, from private foundations and individuals, from semigovernmental agencies and institutes. Were this to be seriously reduced, it would require a 50% increase in our state appropriation, or the loss would collapse the entire organization and operation that has cost so much in money, in time, in sweat, blood and tears.

No longer would it be realistic to take off the cream that is research and leave the skim milk to be called teaching. Teaching and research are inseparable in modern medical education and so are research and service in a teaching hospital. I am not familiar with any other medical school budget that has no item labeled for research; South Carolina is fortunate that we have earned that third of our budget from other sources.

Medical School Admissions

Another factor of great concern to everyone and particularly to the members of the profession, but most acute with the admissions authorities, is the very difficult matter of selection of medical students.

At a time when it has been reported that there is a slackening in applications from desirable candidates at other schools, we are having the opposite experience. Apparently we have become attractive to those who aspire to medicine.

For a class limited by accommodations to 80, we have before us this year forty odd South Carolina doctors' sons, more than thirty

applicants from Columbia, comparable numbers from Charleston, Greenville and other cities, and a thick scattering over the entire state.

Along with other critical factors, this means that scholastic grades and figures will have to be even more of a point of decision than heretofore. In the eighty selected we shall make few friends; among the disappointed will be many disgruntled.

Summary

In bringing this rather disjointed review to a conclusion, I wish to say that the medical profession of South Carolina has been very kind to me. I have been permitted to join with it in practically complete revision of medicine and of medical education in South Carolina, to my deep satisfaction.

In drawing the plans for the present era of medical education the profession gave its wholehearted, active and decisive support.

It is now essential that we secure an active revival of that backing, else we may not succeed fully in the job expected of us.

It is a "must" that our budgets for 1958-59 shall be met—that the "operational" budget of the school be supported by an appropriation of \$1,074,000, and the hospital budget at \$1,500,000 plus hospital revenues.

Although it is fully recognized that we live in a time of danger, at least as yet that does not require that we make all-out sacrifice of our advances in other things than satellites. For emphasis I repeat—we must cultivate the *life* and *happiness* sciences as well as the death and destruction sciences.



STATE ASSOCIATION—MEDICAL COLLEGE RELATIONSHIP

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As the annual meeting of the South Carolina Medical Association approaches, it may be well to review and bring up-to-date the question of establishing a professional relationship between the State Association and the Medical College. It is not a question of supporting or hindering medical education, and certainly it is not one of being for or against the Medical College. The physicians of the state have given ample evidence of their loyalty in the past, and at present by strongly supporting the College in its expansion program. It is fundamentally a question of medical and economic ideology as to whether a state supported educational institution engaging in the private practice of medicine should be to a great extent autonomous, and responsible only to the legislative body which makes the appropriation. To express it in another way, would an official relationship between the State Association and the Medical College be harmful or beneficial to the cause of education and the standards of the practice of medicine in the state? Would it be harmful or beneficial to the medical economy of the state particularly as regards the welfare of community hospitals? The decision is important to the state as well as to the medical profession both at present and more so for the future. The question should be decided upon its merits; extraneous matter should not enter into the consideration.

The Medical College Hospital was established as an affiliate of the Medical College to meet the present requirements of medical education and to provide, in the state, skills and facilities which for economic and other reasons, are not generally available in community hospital, and thus lower the standards financial obligation of the state, justified as a

sound investment in improving the standard of medical care in the state. It is essential that it receive from the state an appropriation adequate for plant maintenance and professional salaries so that it will not be forced to seek income from that field of patient care commonly considered the province of the community hospital, and thus lower the standards of hospital care in the state. While the admission policy of the Medical College Hospital is to accept cases referred for special skills and facilities such a policy is difficult to enforce particularly in the private patient category. While it is necessary that the patients in the Medical College Hospital be subsidized so as to obtain sufficient material for teaching purposes, the proper use of this subsidy and the prevention of its abuse present complicated and far reaching problems. These problems concern not only education but also the practice of medicine and particularly the welfare of community hospitals.

The Medical College Hospital as an institution and through its individual faculty members is increasingly engaging in the practice of medicine at the various economic levels. Deriving financial support from a legislative appropriation, it is not subject to the same economic controls as community hospitals dependent almost solely upon income from services to patients. The Medical College Hospital is now a dominant factor in determining service charges to patients and the pay scale to ancillary personnel in other hospitals. While its room rates are based upon those of other hospitals in the area, community hospitals cannot offer patients the same physical advantages without increasing rates beyond what the average patient can pay. At the present time the least expensive private room with toilet at a neighboring hospital is \$17.00 a day while at the Medical College Hospital it is \$13.00 a day. In both institutions the charges are the

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same for the four bed wards. At the Medical College Hospital telephone and summer air-conditioning are included in the room service, while at the other institution there is an additional charge for these facilities.

The South Carolina Medical Association is recognized as the official representative of the medical profession of the state. The Federal Government consulted this representative in forming the Medicare Program. It makes nominations to the Legislature for the State Board of Medical Examiners and the Industrial Commission. The South Carolina Medical Association has been designated by the Legislature as the State Board of Health and its representatives serve on the Executive Committee. Through its representative bodies it determines the policy of the spending of large sums from the state and federal governments for public health measures, various agency cases, and hospital construction. It takes an active part in public health legislation. It is the corporation of Blue Cross, Blue Shield and it appoints the Boards of Directors. The South Carolina Medical Association is entrusted with such responsibility as it is the recognized liaison between the physicians and the public in matters concerning professional and institutional practices affecting the health of the people.

It naturally follows that there should be an official connection between the Medical College and the South Carolina Medical Association as is the case with other State Medical Institutions. While the Board of Trustees of the Medical College is composed of practicing physicians and deserves great credit for the expansion program, it is appointed by the Legislature to serve the Medical College which is supported by an annual appropriation of over two million dollars. As the Medical College Hospital is becoming an increasingly important factor in determining professional policies and the economics of medicine, particularly in community hospitals, its Board of Trustees could not properly be considered as officially representing the physicians of the state, particularly in the field of the practice of medicine in case of any differences of opinion or conflicting interests of professional policies or institutional practices. The best way

to maintain an official connection between the Medical College and the physicians of the state is through a standing committee of the South Carolina Medical Association. This would not constitute any abrupt change as there already exists a close but informal relationship through the physician composed Board of Trustees. The province of this committee would cover particularly professional and economic matters pertaining to the practice of medicine, a field of mutual interest to the profession at large and the Medical College Hospital. It should be recognized that education, research, and those frontiers of medical practice which are costly are peculiarly the province of the Medical College.

With the tremendous increase in health insurance in various forms, the practice of medicine is becoming more and more complicated. New problems of both economic and professional nature are constantly arising. Channels of communication should be established so that solutions can be sought. Where medical colleges have not had an official connection with their state association, serious differences have arisen, particularly in the field of the practice of medicine. Efforts should be made to prevent such difficulties in South Carolina while the Medical College Hospital is still in the developmental stage.

The establishment of such a committee should be of much value to the Medical College. An important function of such a committee would be to advise the State Association as to how it could best use its support for the development of the Medical College. It should also advise the Medical College how it could best serve the needs of the practicing profession, the support of which is essential to its success. The very fact that such a committee was functioning would place the Medical College in a favorable light as regards working with the practicing profession; it would also serve to protect the Medical College from misguided criticism. It would place the State Association in a position to approve of the policies and plans of the Medical College and support it in its budget presentation. Should a precedent be desired it can be cited that the Medical College requested and obtained official approval of the South Carolina

Medical Association for the construction of the Medical College Hospital. This relationship should have been continued.

Over the years, the South Carolina Medical Association, representing the physicians of the state, has accepted public responsibilities. It has discharged its trusts faithfully and competently to the best interest of the health of the people of the state. There is no just ground for apprehension concerning the proposed relationship between these two public service institutions. There is no reason to fear hampering restrictions being placed upon the Medical College, as it has the loyal support of the physicians of the state. The establishment of a working relationship should be a natural development beneficial to both the Medical Col-

lege and the practicing profession, and, at the same time, to the best interest of the public. The time to establish an official connection between the South Carolina Medical Association and the Medical College is now. There is no good reason for putting off what should have been done some years ago. Experience in other states indicates that delay would only add to the difficulties. Recently the House of Delegates of the American Medical Association has reiterated its stand that there should be liaison committees between medical schools and their state associations. The first point in the Ten-Point Program adopted by the South Carolina Medical Association is, "To promote closer cooperation among agencies providing medical care in South Carolina."

Why Glasses? J. W. Jervy, Jr., Greenville, Tri-State Med. Jour. 5:15 (Jan. 1958)

Glasses are desirable only to enable one to use comfortably what potentialities for vision already exist. No one has ever been harmed by a dime store glass. The over the counter purchaser at least is not in the care of untrained persons who purport to "examine eyes" and who accept and foster the unearned appellation of "doctor". Failing students only too frequently get in the hands of one whose main purpose is to make a sale. All should know and none forget that the doctor of medicine is the only one capable of recognizing and treating disease whether in the eye or elsewhere. It is to be hoped that all men will some day realize of how little importance glasses are to the health of the eyes and how very desirable is the skillful service of the eye physician.

Sporadic Cretinism with Goiter Occurring in Identical Twins. H. F. Frierson, J. C. Hawk, Jr., and Margaret Jenkins (Charleston) J. Pediatrics 51:704, December, 1957.

Cretinism occurring in areas where goiter is not

endemic is known as sporadic cretinism. This rare type is usually of the athyrotic type and not associated with goiter. It is rarely familial. Cretinism with goiter rarely occurs in non-endemic areas and there is a high familial incidence of this type of hypothyroidism.

This article reports this occurrence in identical twins.

Identical female twins were first seen at the age of 3½ months, each having a mass in the right side of her neck. Each was having respiratory symptoms from the mass, which at first was thought to be a cystic hygroma.

At the age of 6 months operative removal of the masses was contemplated, but at this time the children were thought to have cretinoid appearance and the mass was thought to extend across the midline of the neck. Aspiration biopsy proved the masses to be thyroid tissue with folliculoid arrangement but no well developed acini or colloid.

The twins were then begun on thyroid substance. Within a month the neck masses had disappeared.

When seen at the ages of 16 and 23 months, the children were apparently having normal mental and physical development.



PRESIDENT'S PAGE

It is traditional with the medical profession that the prime interests of its members are humanitarian and scientific. This is as it should be. It is, at the same time, the natural *result* of their experience and contact with patients, and the *cause* of the high esteem in which the profession is held.

Within the past two decades the doctors have discovered another channel for their interests and activity, one that concerns the public generally. They have come to realize that it is their duty to make their voices heard in matters of government and they have discovered that a tremendous influence can be exerted when they undertake to do so. The discovery developed both from necessity and the truly increased interest of the doctors in public affairs. When the sustained drive for compulsory health insurance began the doctors throughout the country rose in unison to oppose it, and the result was dramatic. If "socialized medicine" was not permanently prevented, at least it was postponed and its adherents were forced to change their tactics.

This new interest is decidedly on the profit side of the ledger. In connection with it, however, there are two or three things which the doctors cannot afford to lose sight of. First of all, that, as we said in the beginning, not only their primary but their ultimate concern is and must continue to be for the humanitarian and scientific side of medicine. Second, that their interest in government and the public welfare must be genuine, sincere, and sustained. Third, that they cannot afford to be constantly and always in the forefront of legislative battles; and finally, that their influence and the public's confidence must not be prostituted for the purpose of advancing any single economic or political doctrine.

There is a great tendency in most county medical societies to disregard the meetings given over to consideration of political and public affairs, as distinguished from a scientific program. We must not forget that the former relate to a most important part of our lives in our communities. And let us always temper our interest in matters of politics and government by determining whether the projected action meets two qualifications:

First, that the matter is one of legitimate interest for the medical profession, and second, that we are really on the side of the ultimate good of the public at large.

D. Lesesne Smith, M. D.

Editorials

THE ANNUAL MEETING 1958

The 1958 annual convention of the South Carolina Medical Association will be held at Myrtle Beach on May 13, 14 and 15. The Ocean Forest Hotel will be headquarters, and it is expected that there will be a large attendance and an enjoyable occasion. The program and information about the speakers appear in this issue, as do as many committee reports as could be obtained, and also information about the commercial exhibits.

The business session will begin on May 13 and continue into May 14, ending before the start of the scientific program at 3:00 p. m. on Wednesday, the 14th. The program offers a variety of scientific fare, and the speakers are outstanding.

Entertainment in attractive form will be offered, and there will be ample opportunity for relaxation during the convention. This is an opportunity for all of us to participate in the activities of the Association and to get a few days' time for a change from the routine of practice.

A large attendance is anticipated.

A HOME FOR THE ASSOCIATION (?)

It is time that the rank and file of the Association membership began thinking of and discussing among themselves the question, should the Association acquire a headquarters building. For several years, this question has received some thought by Association leaders. Two positive steps were taken at the annual meeting last spring: A committee on a home building was set up by Council, and an annual assessment of \$5.00 to be earmarked for a home building fund was voted by the House of Delegates. These two actions and particularly the second would seem to imply that the Association is already committed to a plan of acquiring a home. However, that is not necessarily true. Such a plan could be postponed indefinitely.

Only yesterday, I was asked the question,

Why does the Association need a building. Although, I am a member of the committee set up by Council, I found it a little difficult to answer the question convincingly.

Certainly, the answer is not because certain leaders wish it. Nor is it an answer to say that we must move the headquarters away from Florence. The answer, to be effective, must state some positive reasons why the ownership of an Association home would be a wise investment of money.

The Association already has a considerable reserve, some of which is bearing interest. There is an annual expenditure for necessary rental space. For a good many years, the offices have been located in Florence, which is not a central location. Because it is not central and perhaps because the offices include no suitable meeting space, no council meeting, no conferences and no committee meetings have been held in the headquarters offices.

The Association is more and more asserting a leadership in medical affairs of the state. Legislative bills are being examined. Efforts are being made to influence legislation. A home office building in Columbia would increase tremendously the legislative prestige of the Association. The administrative officers, and particularly the Executive Secretary, would be available for ready conference and consultation by legislative leaders.

The Association's business has become big. It requires careful supervision, careful planning, and careful auditing. As it is now, the Executive Secretary's office and his clerical assistants are in Florence, the treasurer is in Florence, the chairman of the Council is in Mullins, the secretary is in Charleston, the editor of *The Journal* is in Charleston, *The Journal* is printed in Greenville, and the archives, as valuable as they are as historical documents, are scattered and are not protected from fire and water hazards, nor is there any assurance that they will not be lost.

Have I, in describing the present situation, by indirection indicated adequate reasons for

acquiring a permanent home? That is a question that each member must determine for himself. His regularly elected representatives in the House of Delegates will sooner or later have to answer that question.

To help me answer it, I wrote to the Executive Secretaries of the Associations of several southeastern states for information. I asked the following questions: What facilities are included in your building? Is there a library, and if so, is it a medical library or a specialized type of library? Is there a committee room or an auditorium, and if so, how large? To what uses are the facilities of the building put other than those of the executive secretary and his staff? The approximate investment in the home? Is there any rental space included in the building?

I have heard from the following executive secretaries: Medical Association of Georgia, Mississippi State Medical Association, The Medical Society of Virginia, Tennessee State Medical Association, and Florida Medical Association.

Georgia does not own its own building but occupies 2000 square feet in the Fulton County Society building. This space is all used for offices. In addition, the State Association has access to a 350 seat auditorium, a kitchen and dining room accommodating 200 people, and two conference rooms. A rental of \$1,500 a year is paid. Even though this arrangement is amicable, more space is needed. Tentative plans are already in the works looking toward the building of about 6000 square feet, adjacent to the county building so as to continue to use its auditorium and kitchen. It is estimated that the kind of building desired would cost about \$90,000.

Mississippi has been in its building for about eighteen months and is already finding it a little too small. It has 4400 square feet of space. It contains offices, a conference room, a kitchenette, storage and service rooms. There is no library but a modest archives for non-scientific medical information in the President's room, which also serves for a small conference room. There is a larger conference room, seating at a conference table up to eighteen. An auditorium was decided against because of low utilization and the necessity

for making such a facility available to outside groups.

Use of the building is limited exclusively to activities of the State Association. There was included in the plans no rental space. The investment in land and building alone is about \$150,000.

The Medical Society of Virginia will occupy its new building in June. The first floor contains four offices, a lounge, a work room, a storage room, a conference room which will seat 60, and a kitchen.

The second floor will contain offices to be used by The Virginia Academy of General Practice and the Virginia State Nurses Association.

There will be no medical library, but there will be a reference library for use by committees.

The entire investment in land and building will be a little more than \$100,000.

Tennessee has occupied its building for slightly more than two years. It contains 4000 square feet of space. It is strictly an office building, with executive offices, work rooms, board and committee rooms, mailing and storage facilities. Two small offices are rented to the county medical society. There is no library and no auditorium. The investment in land and building is about \$65,000.

The Florida Association plant cost about \$157,000. About \$13,000 more was spent in furnishings, landscaping, etc. The building contains 8-9000 square feet. There is no medical library, but there is a small reference library. There is no auditorium. There is a board room which will seat 20 people. No rental space is included. In addition to the normal activities of the executive office, the building is used for committee meetings and those of allied and ancillary groups.

It is my belief that our Association needs a home office and that it should be located in Columbia. Such an investment, I believe, would be financially sound. We would need about 6-7000 square feet of space. My guess would be that we could get what we need for about \$100,000.

The building should include adequate and well arranged offices, a conference room large enough to seat the Council comfortably, a

fireproof archives room, and a room for a small special library.

J. Decherd Guess

MEDICAL EDUCATION WEEK

April 20-26, 1958

Each member of the South Carolina Medical Association has an opportunity this month to both honor and aid his medical school by helping bring the third annual observance of Medical Education Week to the attention of his patients and the public.

During the week of April 20-26, the medical profession will join forces with the Woman's Auxiliary and the medical schools throughout the country in presenting programs emphasizing the progress, problems, and challenges of medical education. The world leadership of American medical schools, their expanding enrollments, research triumphs, and community services are little known by the public at large, and Medical Education Week is designed to create greater public appreciation and support for their continuing achievements. At the same time, it will stress the problems which the foreseeable future holds—increased competition for the qualified school candidate, greater facilities for teaching the growing complexities of medicine, and the need of an expanding and aging population for more doctors. And, not least of all, is the immense cost of medical education which already is a \$200 million annual undertaking.

The six specific aims of Medical Education Week, which our society, in cooperation with our Woman's Auxiliary and the Medical College will stress through local radio and television programs, newspaper features, and presentations to community organizations, are to:

- 1—portray the key role that medical education plays in the promotion and maintenance of the nation's health and security, and make the public aware that the nation's 83 medical schools are the foundation of our entire health and medical structure;
- 2—explain how the medical schools are striving to meet the demand for larger numbers of physicians and, at the same time,

characterize American medical education;

- 3—call attention to the steady progress in the medical sciences, showing what this means in terms of longer life, better health and greater freedom from disease and disability;

- 4—point out the wide range of activities—teaching, research, service and leadership—carried on by the modern medical school in addition to its job of training new doctors;

- 5—make clear the extent and nature of the new challenges to the profession, some growing out of our constantly expanding fund of medical knowledge and some resulting from the mounting complexity of our civilization, and

- 6—point out some of the steps being taken constantly to push back the horizons of the medical sciences and to realize the full potential of the nation's health resources.

These objectives will be further emphasized in a coast-to-coast promotional effort now being planned by the national sponsors of Medical Education Week—the Association of American Medical Colleges, the AMA and its Woman's Auxiliary, the Student AMA, the National Fund for Medical Education, and the American Medical Education Foundation. Programs and salutes, supplementing our local observance, will be carried on network radio and television, in national publications and syndicated newspaper features, and through civic and industrial organizations.

President Eisenhower, in his personal endorsement, has already invited the American people to set aside this Week to consider the work of our medical schools, but its ultimate success will depend most directly on how well and how actively we initiate and conduct this annual community salute to our medical schools . . . Medical Education Week, April 20-26!

A SALUTE TO
MEDICAL SCHOOL PROGRESS
MEDICAL EDUCATION WEEK
APRIL 20-26

A HOME FOR THE ASSOCIATION

At a recent committee meeting some of the advantages of having a permanent home for the State Association were discussed.

They are as follows:

1. It would contribute toward a more efficient and economical administration.
2. It would give an opportunity for better public relations between the medical profession of the state and the public.
3. It would represent a permanent tangible building with which to identify the State Association.
4. Eighteen states, among them Georgia, Florida, Mississippi, Texas, Tennessee, and Virginia own permanent buildings to house their state associations and find it advantageous.
5. It offers more adequate protection for preserving both current and historical records.
6. By offering a place for preserving portraits of former prominent members, it would encourage the donation of such portraits by the present owners.
7. The cost of such a building could be amortized over a period of about ten (10) years both from annual assessments from members and from the savings of the present rental price.

The Committee recognizes the fact that first things must come first and the initial step in this matter is to sound out the medical profession in the state as to its present feelings about establishing a permanent home. The Committee will welcome thoughts from the members on this subject so that we may know how to proceed.

R. W. Hanckel,
Member of the Permanent
Home Committee

Other members of this committee are:

O. B. Mayer, M. D., Columbia, Chairman
Dechard Guess, M. D., Greenville
Kenneth G. Lawrence, M. D., Florence

THE DOCTOR'S WAY

During the past fifty years the medical world has probably seen the greatest advancement in the prevention, diagnosis and treatment of disease of any period of its history.

During this same time 'the doctor' has catapulted from a position of love and respect to one of distrust and ridicule. It is so easy to say that the public is grossly unappreciative of what the medical profession has done for mankind; or that the government's efforts to socialize medicine are the responsible factors. But these things are not true; the responsibility lies directly on our doorstep.

In the January 1957 *Medical Economics* there appeared a very self-critical article by Dr. Francis T. Hodges, entitled "Medicine's Seven Deadly Sins". Maybe you read it and felt, as I did, that Dr. Hodges' charges were true. Whatever our "sins"—the reasons for the nose-dive of our professional esteem—I am firmly convinced that an answer lies in improvement of the fellowship relations between doctors and their "public".

It is said that in the early days of the old Roman Empire, manufacturers of earthenware often put wax, or *cera*, on the jars that were cracked in order to hide their defects. When purchasers wanted to buy jars, they asked the vendors whether the pottery was without wax—*sine cera*—thus solid, genuine, and intact. In this way, some say, began our word "sincere". Whatever the origin of the word, wax-less sincerity is the first requisite for lasting good fellowship. In our dealings with others, our motives must be unadulterated by false polish or veneer.

Likewise, our relationships must be untainted by snobbishness. So the second ingredient of good fellowship, it seems to me, is equality. It is quite natural in any society that some are more intelligent than others; some are richer; some have higher social standing. But if we are to recognize the worthiness and the usefulness of all of God's creatures, we must accept each other on a basis of equality.

However much other people may be drawn to us, unless we ourselves express a return of their affections, no true fellowship can grow. The beautiful human sentiments must be fed and sprinkled. We must reciprocate. We cannot order patients and associates to love and respect us. We cannot force such rare intangibles upon people. They must be developed and inspired. We enjoy respect and love as we ourselves are willing to return

them. This points out another ingredient of fellowship—mutuality.

To achieve this mutuality, we must often exercise our tolerance. So we should add this virtue to our list of fellowship ingredients. Unless we are sympathetic with the faults of our fellowmen, and take cognizance of our own faults, it is well nigh impossible for us to call them friends.

Tolerance, of course, does not mean the sanction of what is wrong. It does not mean the abandonment of principles. But it does exclude the unreasonable condemnation of those who hold ideas different from our own.

While we practice tolerance, we must take care to adhere to principles. No true man can long tolerate those who have no regard for high moral and ethical standards. No group of men profess a higher ethical standard than we of the medical profession. But how often has our Hippocratic Oath been allowed to degenerate into a hypocritic oath? We have all heard that the letter of the law killeth, but the spirit of the law giveth life. It is sound counsel for fellowship as well.

And there we have it: five ingredients for good fellowship—sincerity, equality, mutuality, tolerance and adherence to principle. From them are made the atmosphere of goodwill for doing good works.

Martin M. Teague, M. D.

NEWS

FEDERATION OF STATE MEDICAL BOARDS

The annual meeting of the Federation of State Medical Boards of the United States was held in Chicago February 8-11 in conjunction with the Annual Congress on Medical Education and Licensure. Dr. John Cuttino moderated a well attended institute on bacteriology and was commended for his efficient handling of its proceedings. Three other institutes were held at the same time on the subjects of pathology, anatomy, and surgery. These institutes have become a regular part of the Federation meetings. Members of the various state boards who examine in the subjects being discussed are invited to attend and participate in the discussions. The purpose is to improve the examinations, stimulate the individual examiner to improve himself, provide some degree of uniformity between the examinations of the forty-eight states, and to attempt to focus the questions on

fitness testing by interjecting a patient problem into each question rather than testing for factual knowledge as is done in medical college.

At this year's Federation meeting, there were representatives from practically all of the state boards, with full membership being present from several of the states. The Nebraska board was cited for having all of its members present for the eighth consecutive year.

At the business meeting a resolution was passed recommending that each state seriously consider having a requirement for annual or biannual registration of physicians. It was pointed out among other things that only in this manner could the board know and keep track of all the physicians registered in the state and it also allowed the board to exercise much better control as it was intended to do.

The officers of the Federation for the coming year are: President, Wesley D. Richards, M. D., Chairman of the Board of Medical Examiners of Pennsylvania; President-Elect, E. H. Lawson, M. D., Secretary of the Louisiana Board of Medical Examiners; Vice-President, Harold E. Jervey, Jr., M. D., Secretary of the State Board of Medical Examiners of South Carolina; Secretary-Treasurer, Walter L. Bierring, M. D., Secretary of the Iowa Board of Medical Examiners. The members of the Executive Committee are: W. C. Foster, M. D., Acting Secretary of the Board of Medical Examiners of Oregon; Lewis Jones, M. D., Secretary of the California Board of Medical Examiners; E. C. Swanson, M. D., Secretary of the Michigan Board of Medical Examiners; C. E. Glaspel, M. D., Secretary of the North Dakota Board of Medical Examiners.

COURT UPHOLDS DISCIPLINARY ACT

Ralph Neill, executive secretary of the Washington State Medical Society, reports that the Supreme Court of Washington has affirmed the action of the disciplinary board operating under the Washington medical disciplinary act.

The board had suspended the license of a physician who was convicted of violating the internal revenue code by filing a false and fraudulent income tax return. This is believed to be the first case to have come before the Supreme Court of Washington under the medical disciplinary act which was adopted in 1955.

Drs. Nachman and Armstrong announce the removal of their offices to a new location at 413 Vardry Street, No. 1 Vardry Street, Medical Court, Greenville.

Dr. Fred Kredel presented a paper on "Security Measures in Cancer Operations" before the Tri-State medical group from South Carolina, North Carolina and Virginia on February 17.

A summary of studies in the field of kidney infection as it relates to hypertension was presented by Dr. Cheves McC. Smythe.

Dr. I. Ripon Wilson of Charleston is a councillor of the association.

Dr. Owen Meredith, associate radiologist at Anderson Memorial Hospital, and M. L. Meadows, executive secretary of the South Carolina Medical Association spoke at the February meeting of the Anderson County Medical Society.

At a recent meeting of the Barnwell County Medical Society, Dr. L. W. Anderson of Williston was elected president for the coming year. He will succeed Dr. E. R. Wallace, III, of Barnwell.

Other new officers are Dr. J. F. Kneece of Blackville, vice president, and Dr. L. M. Mace, of Barnwell, secretary-treasurer.

Dr. John Fleming of Spartanburg was named medical delegate member of the American Cancer Society at a meeting of the executive committee of the South Carolina Division at state headquarters in Columbia, according to Dr. Thomas A. Pitts, chairman.

Dr. Harold Pettit of Charleston was voted alternate, Dr. Pitts said. The new medical delegate member replaces Dr. John K. Webb of Greenville, who completed two terms of office at the end of 1957. A lay delegate member will be elected at a later date, Dr. Pitts said.

The Coastal Medical Society met February 20, 1958, at Padgett's Pond (near Williams).

The program was a panel on Carcinoma of Cervix composed of Drs. Lawrence Hester, Edw. McKee and J. J. Kane.

A special effort to have children under 5 vaccinated against polio has been announced in the wake of new evidence that this is the age group with the highest attack rate for paralytic polio.

Surgeon General Leroy E. Burney of the Public Health Service said he had called this information to the attention of the American Academy of Pediatrics and the American Academy of General Practice and that both will encourage vaccination of children under 5.

The Public Health Service will continue to urge vaccination of all persons under 40, with special emphasis on the under 5 age group, and the Children's Bureau, also an agency of the Department of Health, Education, and Welfare, will join in this phase of the campaign, Dr. Burney said.

Dr. R. W. Ball, chief of the VD Section of the State Board of Health, was one of the principal discussants at a Venereal Disease Seminar held in El Paso, Texas, during the week of January 20. This was the first annual conference held by the VD branch of the Public Health Service only for health department delegates from states west of the Mississippi.

SCOPE WEEKLY shows a picture of Dr. Joseph P. Cain, Jr., Mullins, moderating a panel on evaluation of low back pain disability at 18th annual Congress on Industrial Health in Milwaukee.

MEDICAL COLLEGE IS AWARDED GRANT

The Medical College of South Carolina has been awarded a \$34,825 grant by the National Fund for Medical Education.

The grant is a part of \$3,178,825 awarded to this country's 82 medical schools.

The grants are unrestricted, but are used chiefly by the medical schools to retain valuable faculty members, fill vacancies and open new courses in fields of scientific progress.

The Medical College received a lump sum of \$15,000 plus \$65 per undergraduate student. The award was made to the Medical College of South Carolina on the basis of enrollment of 305.

A total of \$100,000 was set aside by the fund for special purpose grants to various schools. S. Sloan Colt, fund president, said the contributions of 2,662 corporations and individuals were matched by contributions from the Ford Foundation.

Colt said the total amount of grants made since the National Fund for Medical Education began making such grants in 1951 is \$15,843,766.

The fund was formed in 1949 under the leadership of President Dwight D. Eisenhower, former president Herbert Hoover, now chairman of the fund's board of trustees; Dr. James B. Conant, former president of Harvard University and also a former U. S. ambassador to West Germany.

Dr. Walton W. Hamilton, Greenville radiologist, has been named as a member of the staff of Cannon Memorial Hospital, Pickens.

Dr. Hamilton is a graduate of the University of Georgia and the University of Arkansas. He did his internship at Bellevue Hospital in New York and studied radiology in Presbyterian Hospital in New York.

He served in World War II as a major in the Air Force. He is a member of the American Medical Association and the American College of Radiology and the American Board of Radiology.

Dr. Richard Y. Wescoat, Lancaster physician and one-time Summerville resident, was awarded the Jaycee Distinguished Service Award for 1957 in Lancaster at a banquet held at the golf club there with 150 persons present.

Two additions to the medical staff of the South Carolina State Hospital have recently been made, the hospital superintendent, Dr. William S. Hall, has announced.

Dr. William B. Newton has assumed his position as an assistant physician on the women's service, Col-

umbia Division. A native of Orangeburg, Dr. Newton was graduated from The Citadel, and received his medical degree from the Medical College of South Carolina, Charleston, in December, 1956. He completed a year's internship recently at Columbia Hospital.

Dr. Thomas G. Cooper became an assistant physician on the men's service, State Park Division. Originally of near Columbia, Dr. Cooper attended Clemson College, and was graduated from the Medical College of South Carolina, in June 1956. An internship has just been completed at the Medical Center Hospital in Charleston.

MEDICAL COLLEGE

GRANTS AID RESEARCH PROJECTS

U. S. Public Health Service grants totaling \$108,219 have been recently awarded departments and physicians at the Medical College of South Carolina. Dr. Kenneth M. Lynch, president of the college has announced.

The majority of these grants are continuous.

A heart research grant of \$10,000 has been awarded Dr. Harold Pratt-Thomas of the Pathology Dept.

In explaining the research being conducted, Dr. Pratt-Thomas said "It has been found that children and even new-born babies have changes in their coronary arteries. While these changes are not identical in all respects with those observed in older individuals, the question has arisen whether they may lay the groundwork for the typical arteriosclerotic changes of later years. It is hoped that a study of the coronary blood vessels in young persons will give us information not only as to why these changes occur, but whether they contribute to the eventual development of the fully developed lesion in the adult."

Dr. Leon S. Kind, associate professor of microbiology, has received a grant of \$7,877. Outlining his project, Dr. Kind said, "Mice inoculated with killed whooping cough germs, for some unknown reason, become very susceptible to allergic disease. Discovery of the cause of this increased sensitivity may be of great value in our future understanding of basic mechanisms operative in human allergy."

A grant of \$5,000 a year for three years has been made to the Dept. of Medicine for the study of changes in liver blood flow in patients with jaundice and an hereditary form of anemia called sickle cell disease, restricted in this area to Negroes. Dr. Cheves M. Smythe of that department said so far research has been devoted to perfecting newer methods of measuring liver blood flow with the aid of radioactive tracer substances.

"With new equipment purchased with money from the grant, radioactive substances can be measured in very small quantities," he said.

Dr. Morris A. Gordon of the Dept. of Bacteriology, described his research project, "Differentiation of Fungi by Fluorescence Microscopy", which has been granted \$7,216 as follows: "When more fully de-

veloped, this new procedure is expected to hasten the diagnosis of human fungus infections. We are producing in rabbits anti-serums which react only with a certain species of fungus. This antiserum, when combined with a fluorescent chemical and applied to the specific fungus on a microscope slide, makes the fungus identifiable when ultraviolet light is beamed through the microscope."

The Dept. of Anatomy has received a continuation grant of \$14,693 for study of certain valves in the liver.

The veins of the liver contain sphincter valves which can contract and prevent blood from going forward. They control the flow of blood from the portal reservoir (veins of stomach, intestines, spleen, pancreas and liver) into the general circulation. They comprise the only valve system known which can control the flow of blood to the heart. Dr. Melvin H. Knisely said, "In our laboratory we can send light through the thin parts of the edge of the livers of deeply anesthetized animals and, using microscopes, observe the valves action. We now need to put drugs on the valves and find substances which will cause them to open or close at the command of physicians. In some types of 'circulatory failure' the opening of these valves should guarantee the heart an adequate supply of blood to pump."

A grant of \$18,634, has been given the Dept. of Anatomy for the study of normal, healthy Rhesus monkeys from birth to adulthood. This is being conducted at the Primate Laboratory under the direction of Dr. James H. Gavan. These animals, imported from India, are used for the production of polio vaccine and in medical research. For research to be positively interpreted it is necessary to establish what can normally be expected of these animals in terms of growth, etc. Study of these primates, so similar to man, will also aid in assessing the growth of human children.

A continuation grant of \$8,625 has been made to the Department of Pharmacology for the study of drug actions on the heart. A similar amount also is committed for the next three years, making 14 years of continuous financial support of these studies. Dr. Robert S. Walton said this extended support has permitted the installation and operation of specialized electronic equipment.

Unique force-measuring devices have been developed in this department which give significant new information about heart performance. They are being used in about 25 laboratories in the United States and foreign countries to make direct recordings of heart force during physiological experiments, heart surgery and drug testing.

Dr. James A. Richardson, also of the Pharmacology Dept., has received a grant of \$9,460 for each of the next three years. His work is concerned with the chemical determination of epinephrin in the blood stream by spectro-fluorimetric methods.

A grant of \$7,475 will assist Dr. F. W. Kinard of

the Physiology Dept. in his attempt to explain the marked difference between the reactions of intoxicated individuals on the basis of fundamental enzyme reactions in the brain and liver. "Alcoholism, thought by many to be a metabolic disease, cannot be understood unless the nature of the metabolic deviation can be discovered," Dr. Kinard said.

A grant of \$12,650 will go to Dr. Edwin Boyle, Jr. for use in work to find a quantitative test for serum beta lipoproteins, a factor of the blood serum. The research is an effort to find a screening method by which the general practitioner may determine if his patient is prone to atherosclerosis or, secondarily, to heart disease.

The \$6,589 granted Dr. Lolita Pannell, associate professor of bacteriology is being used in an investigation to determine if a toxin can be demonstrated to be responsible for the symptoms of tularemia (rabbit fever), and related diseases and whether the vaccine can be improved by including the proper stimulants for increased resistance."

The seven-man Citizens Committee named to set up a state rehabilitation center for alcoholics is seeking to "get the maximum use" of the \$75,000 it was given by the 1957 General Assembly.

Attorney Frank K. Sloan of Columbia, secretary, said the committee faced a four-part problem:

Picking a site.

Finding a director for the center.

Exploring all sources of possible additional revenue.

And planning in detail the actual rehabilitation program.

To avoid spending any of its appropriation for land, Sloan said the committee was investigating a number of sites already owned by the state to see if any would be practical for the center.

CORRESPONDENCE

Dr. Kenneth M. Lynch, President
Medical College of South Carolina
16 Lucas Street
Charleston 16, South Carolina

Dear Dr. Lynch:

For the past two years we have been assisting the people of Cobden, Illinois (population 1100), in a program of community development designed to help improve the over-all quality of living. During this time the community has accomplished a number of significant improvements and there has been a truly remarkable degree of citizen participation.

About nine months ago the community sustained a serious blow in the loss of its only doctor by death. Since that time they have done everything they could to find a new doctor but without success.

Cobden is an agricultural community just fifteen miles south of Carbondale, the seat of Southern Illinois

University which has an enrollment of a little more than 8,000 students. In Carbondale there are adequate hospital facilities, as there are in Anna, the county seat, about six miles south of Cobden. Cobden has good schools and other community facilities and is willing to do whatever is necessary to make itself attractive to a young doctor who would like to come and make himself a part of its community.

The community has asked me to write to a number of medical schools to request assistance on its behalf in its search for a doctor. I earnestly request your attention to this matter and will appreciate hearing from you.

Sincerely,
Richard W. Poston
Director

ANNOUNCEMENTS

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS PLAN LOS ANGELES, CALIFORNIA MEETING APRIL 21-23, 1958

Forty round table discussions and 210 breakfast conferences will highlight the meetings of the American College of Obstetricians and Gynecologists at the Sixth Annual Clinical meeting to be held at the Hotel Statler, Los Angeles, California, April 21-23, 1958.

AMA ANNUAL MEETING IN JUNE

Between 12,000 and 15,000 physicians will journey westward in June in search of something far more valuable than gold. They'll be on a quest for the latest information on new medical techniques and discoveries at the American Medical Association's 107th Annual Meeting in San Francisco. The five days of June 23-27 will be filled with bright nuggets—including scientific exhibits, lectures, motion pictures, panel discussions, televised surgical procedures and commercial exhibits. Convenient center for the Scientific and Technical Exhibits, films, color TV and lectures will be the Civic Auditorium, the adjacent new Plaza Exhibit Hall and other surrounding buildings. Headquarters for the House of Delegates sessions will be the Sheraton-Palace Hotel.

FIFTH INTERNATIONAL CONGRESS OF INTERNAL MEDICINE

Philadelphia, Pa. April 24-26, 1958

The world's largest international gathering of scientists and clinicians concerned with internal medicine will take place in Philadelphia on April 24-26 at the Fifth International Congress of Internal Medicine. In issuing the program of the meeting, Dr. T. Grier Miller, Philadelphia, the Congress President, called attention to the fact that in addition to America's leading internists, 81 foreign speakers representing 27

other nations would participate in the Congress scientific program.

Among the 81 foreign speakers will be leading physicians from the Soviet Union, Czechoslovakia, Hungary, Rumania, and Poland. In announcing their participation, Dr. Miller said, "We are particularly pleased at the acceptance by these physicians of our invitation to join us at this International Congress. Their participation emphasizes that medical science knows no geographical or political barriers. It also represents immediate voluntary and professional implementation of President Eisenhower's invitation given in his recent State of the Union Message to the Soviet Union to join with us in cooperative medical research for the betterment of the health of mankind throughout the world."

Information and registration forms for the Congress can be obtained by writing Mr. E. R. Loveland, Secretary-General, Fifth International Congress of Internal Medicine, 4200 Pine Street, Philadelphia 4, Pennsylvania.

THE CHILDREN'S HOSPITAL OF
PHILADELPHIA
AND
THE GRADUATE AND UNDERGRADUATE
SCHOOLS OF MEDICINE,
UNIVERSITY OF PENNSYLVANIA
ANNOUNCE

A Series of Short Refresher Courses in 1958
For Practitioners, Pediatricians, and Clinical
Pathologists

All courses will emphasize developments of the past few years which are important to the physician in practice. There will be panel discussions, demonstrations, conferences and case presentations.

1. "PEDIATRIC ADVANCES". Monday through Friday, May 26 through 30, 1958.

Conducted by the Staff of The Children's Hospital of Philadelphia, in collaboration with the Department of Pediatrics of the University of Pennsylvania.

This course has been given Category I accreditation by the American Academy of General Practice.

TUITION: \$115.00, payable with the application.

* * * *

2. PRACTICAL PEDIATRIC HEMATOLOGY. Monday, Tuesday and Wednesday, June 2, 3 and 4.

1958.

Conducted by Irving J. Wolman, M. D. and other members of the Hematology Department.

TUITION: \$75.00, payable with the application. An illustrative collection of 25 abnormal blood and bone marrow slides has been prepared. These are available for purchase; \$10.00 for registrants; \$15.00 for nonregistrants.

* * * *

3. HEMOLYTIC DISEASE OF THE NEWBORN. Thursday and Friday, June 5 and 6, 1958.

Conducted by Thomas R. Boggs, Jr., M. D. and Milton C. Westphal, M. D. of the Philadelphia Serum Exchange of The Children's Hospital of Philadelphia.

TUITION: \$50.00, payable with the application.

Applications and correspondence should be forwarded to Irving J. Wolman, M. D., Children's Hospital of Philadelphia, 1740 Bainbridge Street, Philadelphia 46, Pa.

DEATH

DR. RICHARD BAKER FURMAN

Final rites were held February 23 for Dr. Richard Baker Furman, 91, who until his fatal illness was the state's oldest practicing physician.

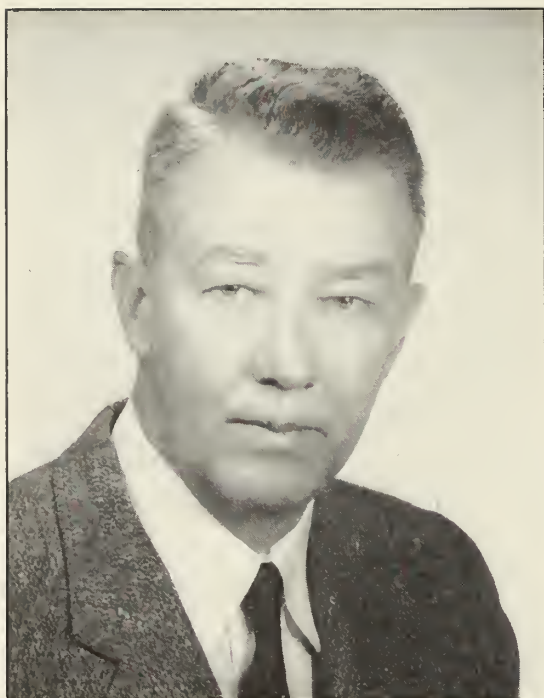
A weathered sign pointing to a side road off Highway 15 some 10 miles southeast of Sumter stands as a monument to the 68 years he practiced there. It reads, "Dr. Furman, Australis." Australis is the name he gave his home. Few ailing persons in that area needed directions as to where to find him, for he had ministered to five generations, including two of the Governors Manning of South Carolina. In recent years he had limited his practice to morning office calls.

Dr. Furman died in a Sumter hospital. Only the night before, his friends and neighbors had paid him their final tribute of his lifetime. They dedicated the new Furman School, named for him.

Dr. Furman was born September 7, 1866, in Privateer section of Sumter County.

Dr. Richard, as patients dubbed him in the early years to distinguish him from his father, went to school in the old log building at Privateer. Later, he was tutored at Sumter. In 1882 he was a member of the first class at The Citadel following the Civil War. He was graduated from the Medical College of South Carolina. He was the oldest living South Carolina graduate of The Citadel.





DR. D. LESESNE SMITH
PRESIDENT



DR. R. L. CRAWFORD
PRESIDENT-ELECT



One Hundred and Tenth Annual Session

SOUTH CAROLINA MEDICAL ASSOCIATION

May 13, 14, 15, 1958
OCEAN FOREST HOTEL
Myrtle Beach, S. C.

GENERAL PROGRAM

• • •

Tuesday, May 13

- 9:00 A. M. Meeting of Council
- 2:30 P. M. House of Delegates (Ball Room)
- 8:00 P. M. Meetings of Reference Committees

WEDNESDAY, MAY 14

- 9:15 A. M. Scientific Films
- 9:30 A. M. House of Delegates Resumes (Ball Room)
- 12:30 P. M. Adjournment—House of Delegates Sine Die
- 1:00 P. M. Alumni Luncheon (Main Dining Room)
- 2:55 P. M. Scientific Session (Ball Room)
- 9:00 P. M. Alumni Association Entertainment (Ball Room)

THURSDAY, MAY 15

- 9:00 A. M. Memorial Service
- 9:15 A. M. President's Address
- 9:45 A. M. Scientific Session Resumes
- 12:45 P. M. Luncheon Recess
- 2:15 P. M. Scientific Session Resumes
- 4:30 P. M. Adjournment
- 7:00 P. M. Refreshments—Courtesy Educators Mutual Insurance Company
- 8:00 P. M. Annual Banquet and Ball (Alumni Association and Guests)

HOUSE OF DELEGATES

• • •

Dr. D. Lesesne Smith, Presiding
Order of Business
Tuesday, May 13

- 2:30 P. M. Call to Order
- Invocation
- Report of Credentials Committee
- Opening Remarks by the President
- Introduction of President-Elect
- Announcement of Reference Committees
- Presentation of Resolutions and Recommendations
- 3:15 P. M. Introduction of Officers and Guests of Woman's Auxiliary
- Reports of Officers

The President
 The Executive Secretary
 The Secretary
 The Treasurer
 The Editor of the Journal
 The Chairman of Council
 The Delegates to the A. M. A.
 Reports of Standing Committees
 Report of State Board of Medical Examiners
 Report of Executive Committee of State Board of Health
 (The reports of the Committees will have been published in the Journal and will not be read before the House. Any supplementary remarks by the Chairman will be heard at this time.)
 Unfinished Business
 New Business
 4:30 P. M. (Special Order) The Annual Meeting of the Corporation, The South Carolina Medical Care Plan
 5:30 P. M. Adjournment Until 9:30 A. M. Wednesday
 8:00 P. M. Meetings of Reference Committees (All members of the Association are invited to appear before the Committees considering matters in which they are interested. Meeting places will be announced.)

Wednesday, May 14

9:30 A. M. Call to Order
 Reports of Reference Committees
 11:30 A. M. Annual Elections
 Officers:
 President-Elect
 Vice-President
 Secretary
 Treasurer
 Delegate to the A. M. A.: (2-yr. term)
 (The term of Dr. George D. Johnson expires December 31, 1958)
 Alternate Delegate to A. M. A.: (2-yr. term)
 (The term of Dr. Charles N. Wyatt expires December 31, 1958)
 Councilors: (3-yr. term)
 Second District (The term of Dr. A. F. Burnside expires)
 Fifth District (The term of Dr. John M. Brewer expires)
 Eighth District (The term of Dr. J. H. Gressette expires)
 Members of Mediation Committee: (3-yr. terms)
 Second District (The term of Dr. Weston Cook expires)
 Fifth District (The term of Dr. Roderick MacDonald expires)
 Eighth District (The term of Dr. W. R. Tuten, Jr., expires)
 Member of Executive Committee of State Board of Health: (4-yr. term)
 (A member will be nominated to fill the unexpired term of Dr. W. R. Mead, resigned.)
 Members of the State Board of Medical Examiners: (4-yr. terms)
 Fourth District (The term of Dr. George R. Wilkinson expires)
 Eighth District (The term of Dr. W. R. Tuten expires)
 Member of State Board of Examination of Nurses: (5-yr. term)
 (The term of Dr. L. Emmett Madden expires)
 Member of Hospital Advisory Council of State Board of Health: (4-yr. term)
 (The term of Dr. William C. Cantey expires)
 Selection of Place for the 1959 Annual Meeting
 Sine Die Adjournment

SOUTH CAROLINA MEDICAL ASSOCIATION

May 13-14-15, 1958

SCIENTIFIC PROGRAM

Wednesday, May 14

- 2:55 P. M. Call to Order
- 3:00 P. M. C. R. Stephen, M. D., Durham, North Carolina
"Anesthesia for the Traumatic Surgical Patient"
- 3:30 P. M. John M. Meredith, M. D., Richmond, Virginia
"Chemopallidectomy for Relief of Parkinson's Disease With Remarks on Selection of Cases for Operation and Improvements in Surgical Technique"
- 4:00 P. M. Recess — Visit Exhibits
- 4:30 P. M. Nathan A. Womack, M. D., Chapel Hill, North Carolina
"Observations on Portal Hypertension"

Thursday, May 15

- 9:00 A. M. Memorial Service
- 9:15 A. M. The President's Address
Lesesne Smith, M. D., Spartanburg, South Carolina
- 9:45 A. M. Isadore Dyer, M. D., New Orleans, Louisiana
"Cesarean Section—Some Unusual Indications"
- 10:15 A. M. Recess
- 10:30 A. M. William S. Kroger, M. D., Chicago, Illinois
"Current Status of Hypnotherapy in General Practice"
Films: (1). "Hypnosis in Obstetrics"
(2). "Hypnoanesthesia in Surgery"
- 12:45 P. M. Luncheon Recess
- 2:15 P. M. Eugene Stead, M. D., Durham, North Carolina
"Reversible Renal Disease"
- 2:45 P. M. Edward Dorney, M. D., Emory University, Georgia
"The Bedside Diagnosis of Regular Tachycardias"
- 3:15 P. M. Clinico-Pathologic Conference
E. A. Stead, M. D., Clinician
E. A. Dreskin, M. D., Pathologist
- 4:30 P. M. Adjournment

Speakers For Annual Meeting

EDWARD R. DORNEY, M. D.



Graduate of the State University of New York — State University Medical Center at New York City — College of Medicine. Internship and Residency at the Brooklyn Hospital, Brooklyn, New York. Formerly in

private practice in Brooklyn, New York. Member, American Federation of Clinical Research. At present, a Cardiologist at Emory University Clinic and Emory University Hospital in Atlanta, Georgia.

Associate in Medicine, Emory University School of Medicine. Diplomate, American Board of Internal Medicine.

E. ARTHUR DRESKIN, M. D.

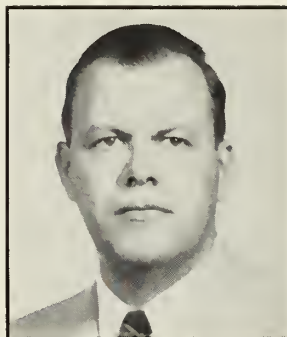


Born January 9, 1919, Newark, New Jersey. Graduated Tulane University of Louisiana, B. S. 1940, M. D. 1943. Internship — Newark Beth Israel Hospital 1943-1944. Active Duty — U. S. Navy 1944-1946.

Resident — Research and Educational Hospitals, Chicago, Illinois 1946-1949. Assistant and Instructor in Pathology — University of Illinois College of Medicine 1946-1950. Fellow in Oncology — University of Illinois 1949-1950. Associate Pathologist — Grant Hospital of Chicago 1949-1950. Diplomate of American Board of Pathology in Clinical Pathology and Pathologic Anatomy 1950. Pathologist — Greenville General Hospital 1950. Member — Greenville County Medical Society, South Carolina Medical Association, Amer. Medical

Association, Fellow of American Society of Clinical Pathologists, Fellow and Member of Assembly College of American Pathologists, Associate Member American College of Physicians.

C. RONALD STEPHEN



B. Sc., M. D. C. M., McGill University, 1940. D. A. (R. C. P. & S.) London, England, 1946. Diplomate American Board of Anesthesiology, 1950. Director of Anesthesia, Neurological Institute, Montreal, 1946-

47 Director, Department of Anesthesia, Children's Memorial Hospital, Montreal, 1947-50. Assistant Professor of Anesthesia, McGill University, 1948-50. Professor of Anesthesia and Chief, Division of Anesthesia, Duke Hospital and University School of Medicine, 1950 to present. Consultant in Anesthesia, Veterans Administration Hospital, Durham, 1953 to present.

NATHAN ANTHONY WOMACK, M. D.



Born Reidsville, N. C., May 24, 1901, B. S. University of North Carolina 1922, M. D. Washington University 1924, graduate training in surgery Barnes Hospital 1924-1930, formerly professor of clinical surgery

Washington University School of Medicine, St. Louis, Missouri, formerly professor and head of the department of surgery, University of Iowa School of Medicine, Iowa City, Iowa, at present professor and head of the depart-

ment of surgery, University of North Carolina School of Medicine, Chapel Hill, N. C.

ISADORE DYER, M. D.



B. S.: Tulane Univ. of Louisiana. M. D.: Tulane Univ. of Louisiana School of Medicine, 1933. Internship: Touro Infirmary, 1933-34. Residency: Tulane Univ. (Resident in Obstetrics), 1934-35. Chicago Maternity Center, Chicago Lying-In Hospital, 1935-36. Teaching Appointments: Tulane Univ. School of Medicine, Professor of Obstetrics, appointed 1950. Hospital Appointments: Charity Hosp. of La. (Sr. Visiting Surg.); Touro Infirmary (Sr. Staff & Executive Comm.); Huey P. Long Char. Hosp., Pineville, La., (Consultant); Lallie Kemp Char. Hosp., Independence, La. (Consultant); Base Hospital, Keesler Air Force Base, Miss. (Consultant). Medical Societies: Fellow, Amer. College of Surg.; Diplomate, Amer. Board of Obst. & Gynec.; Central Assoc. of Obst. & Gynec.; Amer. Assoc. of Obst. & Gynec.; Amer. Coll. of Obst. & Gynec.; New Orleans Gynec. & Obst. Soc.; Diplomate, Amer. Board of Med. Examiners.

JOHN M. MEREDITH, M. D.



A. B. 1927 — University of Pennsylvania. M. D. 1930 — University of Pennsylvania. Fellow in Surgery and Neurosurgery, Lahey Clinic, Boston, 1932-34. Assistant Resident Neurosurgery, Medical College of Virginia, 1934-37. Assistant Clinical Professor Neurosurgery, University of Virginia, 1937-41. Associate Professor Neurosurgery, Medical

College of Virginia, 1941-51. Professor and head of Department of Neurological Surgery, Medical College of Virginia, 1951.

WILLIAM S. KROGER, M. D.

Photograph
Not Available

Associate Clinical Professor of Obstetrics & Gynecology, Chicago Medical School; President elect, Academy of Psychosomatic Medicine; Advisory editor Western Journal of Surgery, Obstetrics & Gynecology;

Advisory Editor Journal of Clinical and Experimental Hypnosis. Author of: Psychosomatic Gynecology; Including Problems of Obstetrical Care; Co-Author, "Kinsey Myth of Female Sexuality"; Co-Author "Hypnosis in Medicine and Surgery"; "Twentieth Century Sex". In publication: "What Price Womanhood"; "Painless Childbirth"; "Hypnosis in Labor". Contributor to many books, scientific publications on psychosomatic Medicine and hypnotherapy.

EUGENE A. STEAD, JR., M. D.



Dr. Eugene A. Stead, Jr. received his B.S. degree at Emory University in 1928 and his M.D. at Emory University School of Medicine in 1932. His house staff training was at Peter Bent Brigham and Cincinnati General Hospital and Boston City Hospital. In 1942 he became Professor of Medicine at Emory University School of Medicine and, in 1945, Dean of Emory University School of Medicine. Since 1947, he has been Professor of Medicine at Duke University School of Medicine.



BANQUET SPEAKER

*MAJOR GENERAL
LEONARD D. HEATON, MC, USA*

Leonard D. Heaton was born in Parkersburg, W. Va., Nov. 18, 1902. He received his M.D. degree from the University of Louisville, in 1926. He was appointed a first lieutenant in the Medical Corps Reserve and assigned to active duty July 17, 1926. He received his regular commission as a first lieutenant in the Medical Corps, Aug. 3, 1927.

After serving as an intern at Letterman General Hospital, San Francisco, General Heaton served tours of duty at Beaumont General Hospital, Tripler General Hospital, and Fort Sam Houston station hospital. His first duty at Walter Reed was in 1928, when he attended Army Medical School.

When Pearl Harbor was attacked in December 1941, General Heaton was Chief of Surgical Service at North Sector General Hospital, Schofield Barracks, Hawaii. He was officially commended for handling of the wounded at that time.

In Nov. 1942 he transferred to Woodrow Wilson General Hospital, Staunton, Va. He was then placed in command of the 160th

General Hospital at Atlantic City, N. J., and took that unit to Europe in March 1944.

When hostilities in Europe ended in 1945, Gen. Heaton was in command of the 802nd Hospital Center at Blandford, England. Gen. Heaton returned to Letterman General Hospital in November 1945, and became Chief of Surgical Service there. In June 1948 he assumed the additional duty of Director of Professional Services at Letterman, and became commanding general of the hospital in July 1950, two months after he was promoted to the rank of Major General.

On April 1, 1953, General Heaton became commanding general of Walter Reed Army Medical Center, Wash., D. C. He is the tenth officer to command the Center, which includes Walter Reed Army Institute of Research, Walter Reed Army Hospital, Central Dental Laboratory, and Army Prosthetics Research Laboratory at its three locations, Wash., D. C.; Forest Glen, Md.; and Glenhaven, Md. He is also the 19th to head Walter Reed Army Hospital component, original installation around

which the Center was formed in 1923.

General Heaton was awarded the Legion of Merit for his work following the Pearl Harbor attack. He also received two Oak Leaf Clusters to the Legion of Merit—one for his work as commander of the 160th General Hospital and the other for his services as commanding officer of the 802nd Hospital Center. In June 1957 the Secretary of the Army presented Gen. Heaton with the Distinguished

Service Medal, the U. S. Army's highest non-combat award.

General Heaton is a member of the Halsted Club, a Diplomate of the American Board of Surgery, and a Fellow of the American College of Surgeons. He also belongs to the California Academy of Medicine, the San Francisco Surgical Society, the Pacific Coast Surgical Association, and the American Surgical Association.



DR. NORMAN EADDY
VICE-PRESIDENT



DR. HOWARD STOKES
TREASURER



DR. GEORGE D. JOHNSON
DELEGATE TO AMA



DR. WILLIAM WESTON, JR.
DELEGATE TO AMA

Committee Reports 1957-1958

REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

As Chairman of this committee, contact was made with the President of the Auxiliary at the beginning of the year and she was asked to advise if at any time we could be of assistance. No calls have been made upon the Committee; consequently, no formal meetings have been held. However, through Mrs. Workman, the President of the Auxiliary, we have been informed periodically as to the various programs which have been outlined and carried out through that organization. It is of interest to the Association that the Auxiliary has been active in:

1. Promoting the enrollment of young ladies in nursing training schools,
2. The dissemination of information regarding the American Medical Educational Foundation and the encouragement of the doctors' wives in aiding this worthy cause,
3. The continuation of the Student Loan Fund in the aid of medical students and student nurses.

The above noteworthy contributions are in addition to continuous efforts to aid the State Association in every way possible. We should like to commend the officers and the membership of the Auxiliary for their

cooperation in carrying out the aims of our organization.

Respectfully submitted,
Thomas R. Gaines, M. D.
Chairman

COMMITTEE ON INFANT AND CHILD HEALTH

The committee met first in June 1957 at which time it was decided to augment the committee by invitation of persons interested particularly in the problems related to newborns. At a later meeting in August 1957 the committee had been increased to include Dr. Heyward Fouché, Dr. Hilla Sheriff, Dr. Sam Garrison, Miss Louella Schloeman (Director, Shriners' Hospital, Greenville), Mrs. Mary Smith (Head Nurse, Nursery, Anderson Memorial Hospital), and Sister Rose Therese (Administrator, Providence Hospital, Columbia).

At the latter meeting we had the pleasure of hearing from Samuel Moss, Ph. D., National Institute of Health, and Dr. Katherine Bain, Assistant Chief Children's Bureau, who came down from Washington to discuss with the committee the possibility of a grant-aided survey in South Carolina to attempt to determine why our infant mortality continues to be so high. At this meeting we also heard from Dr. Charles Williams, Pediatric Consultant to the North Carolina State Board of Health, who told us of a

Neonatal Mortality Study being carried out in North Carolina for the past five years. This has been under the direction of the Committee on Child Health of the North Carolina Medical Society with the cooperation of the North Carolina State Board of Health.

After hearing of these it was decided to initiate a Study of Neonatal Deaths in certain hospitals in this state with the intention of increasing the number of participating hospitals in the near future. This will be a continuing study for the next several years and should both stimulate interest in the causes of neonatal deaths and provide facts about this matter. The State Board of Health is cooperating with this study and has printed the forms necessary. The plan of the study was presented by committee members to the meetings of pediatricians, general practitioners, and obstetricians last fall. This study was started on January 1, 1958, in the following hospitals: Roper Hospital, Medical College Hospital, Self Memorial Hospital, Greenville General Hospital, Spartanburg General Hospital, Columbia Hospital, Marion Memorial Hospital, Cherokee County Hospital, Maternity Shelter in Greenville, and the McLeod Infirmary. At this time it is too early to give any results of this study and we do not anticipate that we will have anything to report until the spring of 1959. At the annual meeting we would like to tell of this study and invite other hospitals to participate in this study.

The committee discussed and studied the subject of adoptions at both the June and August meetings. It learned that there is a new, good, effective law pending in the legislature which should receive the support and backing of the medical association. It is hoped that this will be done.

The matter of insurance coverage during the newborn period was discussed. It is hoped that Blue Cross and Blue Shield will lead the way in providing adequate coverage during this period when medical bills due to congenital defects and neonatal illnesses often produce catastrophic bills for young parents.

The committee feels that the membership in the committee should be changed little if at all the ensuing year in order that those who are familiar with the Neonatal Death Study may continue this work through its formative period. We request that two hundred dollars (\$200.00) be appropriated to continue the committee's work.

Respectfully submitted,

Dr. Ethel Madden

Dr. J. I. Waring

Dr. F. F. Adams

Dr. H. M. Whitworth

Dr. John Bell

Dr. Walter Moore, Hart, Chairman

COMMITTEE ON THE CARE OF THE INDIGENT

While no special legislation has engaged the attention of this Committee during the year, the magnitude of the problem of the care of the indigent on a state and national level merits having a Standing Committee, of which the members serve for a sufficient

length of time to familiarize themselves with the problems involved.

In 1957 your Committee recommended that "a standing committee on indigent care be appointed to be composed of five representative members of the profession with the ultimate aim that each member serve for a period of five years. It is suggested that an appropriate amendment to the Constitution and By-laws be prepared to set up such a committee, the initial group to serve on a staggered basis with the ultimate aim above expressed."

The House of Delegates approved the recommendation and voted that such a five man committee be set up as a Special Committee for 1958.

Your Special Committee for 1958, in line with this recommendation, proposes that the appropriate committee of the State Association be instructed to initiate action to change the By-laws so as to constitute this committee as a Standing Committee of the Association in accordance with the recommendation accepted by the House of Delegates in 1957.

John A. Siegling, M. D., Chairman

Dr. John Brewer, Kershaw

Dr. B. N. Miller, Columbia

Dr. Norman Eaddy, Sumter

Dr. Stanley Morse, Beaufort

COMMITTEE ON AMERICAN MEDICAL EDUCATIONAL FOUNDATION

The State Committee of the American Medical Educational Foundation was organized in early August 1957. Drs. Keitt Smith, George Durst and R. L. Crawford, along with Dr. Howard Stokes, State Chairman, composed the Committee. Since a resolution was passed at the House of Delegates meeting in May 1957 recommending the voluntary contribution of \$10.00 per state member, no further plans were deemed necessary for additional fund raising.

Your Chairman attended the meeting of the "State Chairmen" of AMEF in Chicago in late January 1958 and at first sight saw the tremendous amount of work being done in every state to aid our Medical Colleges. The importance of the AMEF was emphasized by many Deans of Medical Schools as well as other outstanding medical educators and practitioners of Medicine who were present at the Chicago meeting.

The South Carolina Medical College plan whereby, on a voluntary basis, the full time teachers of our Medical College make a very heavy financial contribution to this fund has received attention from Medical Colleges in other parts of the country and has already stimulated giving among physicians.

Our Committee recommends that, if the appointment of this Committee in the future be made in mid-year, the term of office should run from January 1st to January 1st in order that the Committee members might more completely follow the progress of the program.

THE MEDICAL ADVISORY COMMITTEE TO THE CRIPPLED CHILDREN SOCIETY OF SOUTH CAROLINA

The Medical Advisory Committee has not held a State wide meeting up to this time, but plans to have a meeting during the South Carolina Medical Association Convention.

The members of the Medical Advisory Committee in Columbia have advised the Crippled Children Society on several occasions in matters which were generally local. During the Crippled Children's Society Meeting in Columbia in October of 1957, the local members of the Advisory Committee, as well as several out of town, attended the Meeting. They entered into the discussion. The guest speaker was Dr. George Deaver of New York City, who spoke on rehabilitation. One of the Advisory Committeemen introduced the guest speaker at the Meeting. The members of the Advisory Committee present attended an open house at the State Headquarters and met the members of the Board of Directors, as well as other interested personnel.

For a matter of several months, the State Headquarters has been without a physiotherapist. The Columbia members of the Advisory Committee advised on the selection of a new physiotherapist, and an interview was had with an applicant who is apparently going to assume the job as physiotherapist and director of the Clinics at the State Headquarters.

Numerous telephone conversations were had with the State Executive Secretary and advised her on many problems arising from time to time.

James T. Green, M. D., Chairman

COMMITTEE FOR LIAISON WITH ALLIED PROFESSIONS

I beg to submit herewith a report for the Committee for Liaison with Allied Professions, whose membership is composed of Dr. J. C. Scurry, Greenwood, Dr. J. H. Stokes, Florence, Dr. J. R. S. Siau, (deceased) Georgetown, Dr. John M. Pratt, Chairman, York, S. C.

The Committee at the outset felt the heavy responsibility in this era where public relations are emphasized and rightly so, especially in dealing with professions such as the legal, the druggist, the nursing, and the dental, who are so closely allied in every respect with us of the medical profession. Thus, we began to improve and will continue to improve our relations with these various professions.

Our relationship with the legal profession over the years in this state has been most harmonious. This committee has endeavored to improve it by encouraging joint meetings with various bar associations over the state where the films "The Medical Witness" and "The Doctor Defendant" have been shown and panel discussions have been enjoyed by members of ours and the legal professions. At all times we have encouraged frequent and intimate consulta-

tions and explanations between the lawyers and the doctors.

Fortunately, our relationship with our fellow dentists has been on a high level. This we want to continue and to improve. The members of the Board of Trustees of the Medical School, are lending every possible aid to the dental association in their efforts to establish their dental school in this state. Our committee has ever been on the alert to encourage and to voice the sentiments of the South Carolina Medical Association for a 100% effort in this direction. The members of the Dental Association of the state have expressed their appreciation for our understanding of their problems and our efforts in their behalf. The president of the Dental Association is to be frequently consulted and assured of the desire of our profession to assist them in any way possible.

Our committee from the outset has been aware of the shortage of nurses and has exerted every effort in exploiting every recruiting measure available to alleviate this vacuum in the care of the sick of our communities. We have and will continue to avail ourselves of every opportunity to improve the understanding and problems existing between the nurse and the medical doctor. Members of the committee have willingly consented to lecturing to various nursing groups.

By in large, the physician's relations with the druggist of the state remains harmonious and on a high level. The committee has encouraged fellow physicians to be understanding of the druggist's problems and considerate of the many drug detail men that call upon the profession. A cordial relationship with this group of druggists improves the overall relation between the physician and the druggist. A member of the pharmaceutical examining board has frequently consulted a member of our committee in the exchange of ideas in this instance has been beneficial to both groups.

The committee is cognizant of the excellent work done by Dr. Frank C. Owens in getting an Inter-professional Code adopted and this code will be of inestimable value in establishing better public relations and we go on record in commending Dr. Owens.

The chairman represented the committee when he addressed the current officers of the various medical societies in their annual meeting in January at Columbia, S. C.

Very truly yours,
John M. Pratt, M. D., Chairman

COMMITTEE ON HISTORICAL MEDICINE

The Committee continues to function in the way of gathering material for eventual publication. Funds appropriated by the Association now amount to about \$2,250.00, and it is believed that this sum will be sufficient for any present needs and for part of future publication. Therefore the committee is not asking for additional funds at the present moment, but

recommends that this committee be continued with the blessing and approbation of the Association.

J. I. Waring, M. D., Chairman

COMMITTEE ON INDUSTRIAL MEDICINE AND HEALTH

I. Due to the fact that some irregularity and apparent confusion exists in estimation of loss of visual efficiency following industrial accidents and liability injuries, recommendation was forwarded to the S. C. Society of Ophthalmology and Otolaryngology for consideration. The recommendation was for standard use of the method of estimation of loss of visual efficiency as outlined by the Executive Committee of the Section on Ophthalmology and the Council on Industrial Health of the American Medical Association which was approved and accepted by the Section on Ophthalmology at the Atlantic City meeting in June, 1955. The recommendation was to have been discussed at the South Carolina society's meeting in Sept., 1957. We have not been notified of results of the consideration.

II. Medical and hospital care for employees being one of industry's most important considerations today, an article from this committee was published in August, 1957 issue of "South Carolina Business" by the South Carolina Chamber of Commerce outlining standards for company's medical service. Assistance was offered to any company management interested in developing or improving medical services.

III. In August, 1957, the South Carolina Industrial Commission adopted a new and liberalized mathematical formula for computing payments for partial specific loss under the Workmen's Compensation Act. This regulation nullified the rule of proportion for partial incapacity, Section 72-153, Workmen's Compensation Law, and met with general disfavor. A hearing was held Sept. 13, 1957 by the South Carolina Chamber of Commerce to discuss action regarding it. The Committee on Industrial Health was represented at this hearing. Later the regulation in question was set aside by the South Carolina Supreme Court, Feb. 10, 1958.

IV. The South Carolina Accident-Prevention Conference, sponsored by the S. C. Industrial Commission, was held in Spartanburg on Nov. 7th and 8th, 1957. Members of this Committee were active in medical program preparation and participation at the Conference.

V. A program entitled Medicine in Industry was presented to the Pee Dee Medical Association meeting in Feb., 1958, by a member of the Committee. Representatives from Industry in the Pee Dee Section of the State were present with member physicians at this meeting.

VI. In January, 1958, three Bills dealing with workmen's compensation were introduced into the state legislature. These should be of interest to all physicians, and especially to those whose practices in-

clude patients covered by the Workmen's Compensation Law.

House Bill No. 2073 would increase the maximum compensation payable from \$10,000 to \$12,000. This bill actually would not affect medical practice since the S. C. Workmen's Compensation Law places no specific limit on medical expense.

House Bill No. 2074 as introduced would permit an injured employee subject to the Workmen's Compensation Act to select the doctor who would treat him, the employer paying the bills as in the past. The principle of "free choice" actually exists in industrial practice today, and it is felt that this bill was introduced primarily so that claims attorneys could attempt more control over their client's medical treatment and increase their monetary gains at the same time.

House Bill No. 2110 as introduced would provide specific compensation for disability for a back injury under the terms of the Workmen's Compensation Act. This would add back injuries to the scheduled specific disabilities as set forth in Section 72-153 of the Law. This bill did not identify back injuries to the degree that they could be specified and did not agree with principles set forth in usual evaluations.

A hearing was held by the House Judiciary Committee regarding these bills on February 25, 1958, in the State House. A member of the Committee on Industrial Health took part in this hearing, although not necessarily in an official capacity as a representative of the South Carolina Medical Association.

VII. At the May, 1957, annual meeting of the S. C. Medical Association, the Committee on Industrial Health recommended a course in Industrial Medicine be included in the curriculum of the Medical College of S. C. Tentative plans are being formulated for presentation to and consideration by officials of the Medical College. Plans at present indicate a five-hour lecture course that would be presented to members of the Senior Class only. Lectures would be presented as follows: two hours by a physician specializing in Occupational Medicine or a physician qualified in the field; one hour by a lay representative from industry; one hour by an ethical attorney qualified in practice in the workmen's compensation field; and, one hour by a claims representative in the insurance field. Such plan will be submitted when completed and action for or against will be reported.

VIII. On February 15, 1958, the Committee on Medical Rating of Physical Impairment of the American Medical Association published its "Guide To The Evaluation of Permanent Impairment of the Extremities and Back". This Guide was mailed to all physicians receiving the *Journal of the A. M. A.* It is a very complete work and greatly simplifies impairment evaluation or permanent disability estimation of an injured part. In order to standardize procedures, it is recommended and requested that all members use

the Guide in disability evaluation of public liability and workmen's compensation cases.

Dr. John M. Perry, Jr., Chairman
Dr. Leon Poole Dr. James L. Hughes

COMMITTEE ON RURAL HEALTH

The committee on Rural Health, after thorough studying of this problem and conferring with the head of several of the departments of agriculture, Grange organization, thought that no active steps should be given to this rural problem of our association at this time.

We certainly feel like more study and more thought should be given to this Rural problem of our association and certainly a committee should be appointed each year. Should we have a marked recession or depression, the association should take an active part and be the lead in organizing a definite rural health program associated with the Grange or some other State Organization dealing with the rural population.

Respectfully submitted,
Marshall Bennett, M. D.

COMMITTEE ON CORONERS-MEDICAL EXAMINERS

The Committee has held no organized meetings thus far, as the time for major changes or re-organization did not seem propitious during an election year in which a fiscal deficit was a major item on the state's agenda.

The Charleston County Medical Society has manifested interest in this problem and a system is gradually evolving in a local level which might well set a pattern for communities throughout the state.

The problem is one that needs continued study and appraisal. Evolution of a more satisfactory system will undoubtedly be gradual and the continuance of such a committee appears highly desirable.

H. R. Pratt-Thomas, M. D., Chairman

COMMITTEE ON PUBLIC HEALTH

No special communication has been held by the Public Health Committee. The chairman, however, has studied some of the work of public health, especially the extermination of rodents, and spraying, dairying, and cafe inspection, public health for school children, septic tank regulations and recommendations. The chairman of the committee is to attend a school health meeting March 12th., in Columbia in the State Board of Health Building.

This constitutes the extent of our function.

J. C. Harris, M. D., Chairman

SCHOOL HEALTH COMMITTEE

Since a statewide meeting of all County School Health Committees, Health Department personnel,

and invited school and P. T. A. officials is scheduled for Columbia March 12th, this report must of necessity be incomplete. This meeting has been called to discuss with local county committees the plans for the over-all state program, as well as to discuss local problems and plans. Further efforts to cement and correlate our over-all state School Health program with county programs will be attempted.

On September 9, 1957 the present State School Health Committee held its first meeting. The following members were present: Dr. Hilla Sheriff, Columbia, Dr. James Timmons, Columbia, Dr. Robert Brownlee, Greenville, and Dr. Henry Moore, Columbia, Chairman. Drs. William Hendrix and J. R. Paul were unable to attend. The Committee decided that its main efforts should be expended towards effecting and implementing the previous program that has been attempted during the past two years under the capable guidance of Dr. J. R. Paul, Chairman of this Committee since its conception January 26, 1955, and including the years 1955 and 1956. Past efforts had been largely expended toward getting local Committees on a functioning basis. To date, most county School Health Committees still sleep the peaceful sleep of complete dormancy. However, some fruit has slowly grown from Dr. Paul's young trees, and at the beginning of 1957, there were approximately 22 functioning School Health Committees on the county level. Several county Committees have done notably excellent work in their communities and have been most active in consulting with and guiding their local school authorities in School Health matters.

The following objectives are considered of utmost importance in planning our School Health programs and cannot be over-emphasized:

- I. The health of the school age child is a continuing process and should be considered throughout the child's school career.
- II. The family physician is the person best qualified to care for the individual and advise as to his or her medical needs.
 - A. School Round-ups such as have grown up in many communities are a very unsatisfactory and inadequate manner of health examination and should largely be abolished and replaced by family physician supervision.
 - B. Efforts to improve the family physician-patient relationship should be encouraged and will be endorsed by school authorities when the matter is properly presented to them by interested medical persons. Too little value and too much false security has resulted from inadequate school Round-up examinations.
- III. Our Medical Societies should have actively functioning School Health Committees who are always available for consultation and guidance in School Health problems.
 - A. Problems concerning epidemics of illness,

accidents and accident prevention, school diets, physical education, and school accident insurance are certainly problems that can best be resolved by direct cooperation of school officials and medically trained individuals who will give their time to serve on these important committees.

- B. If organized medicine fails to meet its responsibilities in planning efforts for preventing and solving our School Health problems, then we cannot castigate others such as governmental agencies (misguided frequently) when they take over for us.

Beyond the actual health needs of school children, organized medicine has a tremendous opportunity and may harvest many rewards by advising and co-operating with educators as regards improving healthful school environments and physical and emotional educational programs, preventing accidents and emotional traumatic experiences, and giving positive health education methods and teaching.

The Chairman of the School Health Committee has reviewed the excellent recommendations of the State Board of Health for "Emergency Care of Sickness and Accidents occurring at School". These most interesting pamphlets have been prepared under the guidance of Dr. Hilla Sheriff's department and have been distributed to all schools throughout the state. They have been widely used since 1953 and are considered an outstanding accomplishment of the State Board of Health. It is the understanding of the Chairman of the Committee that South Carolina is one of the few states in the country which has such a worthwhile emergency care brochure for school nurses and school authorities. It is felt that these recommendations should be reviewed from time to time by the State Health Medical Committee and any needed additions, deletion, or changes can be brought about through the cooperation of our state committee and the State Board of Health.

On December 13, 1957 several members of the State School Health Committee met with representatives of the State Board of Health and Dr. Shepard Dunn representing the State Ophthal.-Oto-Laryngology Society to discuss the merits and demerits of a proposed eye screening program among school children in selected counties. Volunteer workers were to be trained by Mrs. Florence Cunningham of the National Society for Prevention of Blindness, and these were then to screen certain grades in their respective county schools. Children who failed to meet certain visual requirements were to be forwarded to an ophthalmologist for further examination and corrective treatment when indicated. There were mixed opinions about the accuracy of such testing methods, and Dr. Dunn stated that they would undoubtedly result in over-referrals. However, no better method could be suggested and the State School Health Committee concluded that a trial test was certainly in order, to be done initially on preschool children. Sub-

sequent grades will be screened if the trial study appears worthwhile. The following counties were selected for this study: Anderson, Abbeville, Richland, Lexington, Orangeburg, Allendale, Jasper, Colleton, Charleston, and Florence.

The Chairman of the State Committee attended the Fifth National Conference on Physicians and Schools sponsored by the American Medical Association in Highland Park, Illinois during November, 1957. He left this meeting with several distinct impressions:

First, there are many Do-gooders and Eggheads who are deeply interested and actively concerned with school health problems. Encouragingly, there seems to be an increasing interest in the medical profession also, and if the medical profession is honestly interested in helping and working with our school health problems, then there is still time to give the long neglected guidance that our school educators need and generally want.

My second impression was that there is a tremendous nationwide interest in our children's lack of physical fitness. Many educators and medical men are becoming alarmed at our youth's apparent softness and lack of physical fitness. Can we as medical men sit by without raising a cry of protest against this ever-increasing problem of an increasingly urban population? Will we see that our own children and patients learn to walk to school before they start driving? Will we make more play areas available for the urban child? Can't we teach them to swim before they desperately grab at the proverbial straw? Such matters deserve our best thoughts.

Respectfully submitted,
Henry W. Moore, Chairman

REPORT ON COMMITTEE ON LEGISLATION AND PUBLIC RELATIONS

The laws permitting the practice of Naturopathy in South Carolina were repealed by the 1957 Legislature. The Governor signed the bill and courts have held that the law is constitutional. The Attorney General has notified the S. C. Enforcement Agency of such action by the court, and advised them that action should be taken if the law is violated.

A new bill was introduced in the 1958 Legislature by a representative from Oconee county, who is a Naturopath. Such a bill would authorize the practice of Naturopathy in South Carolina, by a certain group of Naturopaths, previously licensed to practice before a specified date. Another of the bill included a section which would make the State Board of Health responsible for certain inspection powers of the practice of Naturopathy. The Executive Board of the State Board of Health expressed their disapproval by passing the following resolution:

"The question of the Practice and operation of Naturopathy in South Carolina, as well as in other states, has been thoroughly discussed in the Legisla-

tive Halls of this State, with the result that the law and amendments thereto permitting the practice of naturopathy in South Carolina have been repealed. It is felt that this action by the South Carolina Legislature was for the best interest of the people of the State.

The Executive Committee of the State Board of Health therefore goes on record as endorsing this action by the Legislature, and opposes any proposed bill which would again permit the practice of naturopathy in South Carolina."

At present, this bill has been referred to a committee, and from present indications, the committee has shown signs of keeping the bill under their observation.

The Optometrist Bill, which was a source of discussion at the 1957 Legislative session, died at the session. There was some discussion of one being re-introduced and pushed at this session; however, information obtained by your committee indicated that this will not be the case.

Your committee also studied a bill on Privileged Communication. This bill would throw legal protection around certain information obtained by doctors on examination. The legal fraternity of the State has differed markedly on their support of this matter. Your committee has felt that alert observation, rather than active participation, would be the best policy, concerning this bill.

Your committee has been active in acquainting members of the Legislature with the implications of pending legislation affecting the health of the people of the State.

It is noted that a member of the Oconee delegation is a Naturopath. It is also noted that a Naturopath has announced as a candidate for the House from Lexington county. It is incumbent upon the Medical Association to acquaint the public with dangers affecting their health. It is urged that the medical profession not only render service to the State in the practice of their profession, but also exercise their duties as citizens in seeing that proper representation is secured for our public offices.

Dr. Frank C. Owens, Chairman

Dr. O. B. Mayer Dr. Alton Brown

Dr. George Price Dr. Henry Robertson

Dr. George Orvin

THE MATERNAL HEALTH COMMITTEE

The Maternal Health Committee on July 1, 1957 scheduled regular meetings at 2 months intervals. As of April 1, 1957, the Committee is current in its review of maternal deaths in the state. The questionnaire has been revised and is now in use.

The following is a list of maternal deaths by cause in South Carolina for 1956:

Cause	Colored	White	Total
Pulmonary Embolism	6	2	8
Lower Nephron Nephrosis	1	0	1

(following C. Sections)			
Hemorrhage			
Placenta Previa	1	0	
Postpartum Atony and/or Retained Placenta	8	1	9
Abruptio Placentae	2	1	3
Ruptured Ectopic	1	0	1
Uterine Rupture	1	1	2
Pulmonary (Fibrinogen depletion)	1	0	1
Cerebral Hemorrhage	1	2	3
Toxemia			
Pre-eclampsia	1	1	2
Eclampsia	9	3	12
Infection (post-abortion)	1	1	2
Periph. Vasc. Collapse (post-abortion)	1	0	1
Cerebral Embolism	1	0	1
Non-Classified	3	1	4
Total	38	13	51

Summary	
Toxemia	26
Hemorrhage	16
Other causes	16
Infection	7
Ectopic pregnancy	2

It is interesting to note that in 1956 there were 13 maternal white deaths while there were 35,656 white live births. This gives an incidence of 1 maternal death per 2, 743 white live births. Also in 1956 there were 38 colored maternal deaths and 28,155 colored live births or an incidence of 1 maternal death per 741 live births. In 1955 there was a combined rate of 1 maternal death in 941 live births, whereas in 1956 there was 1 maternal death in 1,250 live births, which indicates a definite improvement in the maternal mortality in South Carolina.

Respectfully submitted,
Lawrence L. Hester, Jr., M. D., Chairman

REPORT OF THE EXECUTIVE COMMITTEE
OF THE SOUTH CAROLINA STATE BOARD
OF HEALTH OF SOUTH CAROLINA TO THE
SOUTH CAROLINA MEDICAL ASSOCIATION

The Executive Committee of the State Board of Health has performed its responsibilities this year so as to serve best the public health needs of the people of the state. Public health practice has been designed to continue well-established activities and to promote new programs where the need for such programs has arisen. The Committee members feel that public health work has been carried out in a very satisfactory manner and has been marked by progress on a sound basis.

During the year Dr. W. R. Mead, Vice-Chairman of the Executive Committee, tendered his resignation so that he could accept the chairmanship of the newly created State Alcoholic Board of the State

Alcoholic Rehabilitation Center. The Committee felt keenly the loss of Dr. Mead from its membership, because of his twenty-two years of distinguished and faithful service. The Committee honored Dr. Mead's outstanding contribution by presenting him a plaque in recognition of his service. Dr. Frank C. Owens was elected Vice-Chairman to succeed Dr. Mead. The Committee voted to await the annual meeting of the South Carolina Medical Association to fill Dr. Mead's vacancy on the Executive Committee. Dr. L. W. Busbee, our representative from the South Carolina Dental Association, was reappointed by the Governor to the Committee for a term ending May 31, 1964.

Our capable Executive Secretary and State Health Officer was forced to be away from his duties for several months due to a coronary occlusion. Because of his efficient administrative practices the public health program during his absence proceeded normally with his well-organized staff, under the leadership of Dr. C. L. Guyton, Assistant State Health Officer, carrying out its activities in a very commendable manner. The Committee is very pleased to report that Dr. Peeples is now back at his desk and has assumed the full responsibilities of his position.

In the South Carolina General Assembly there is now a proposed bill to allow the practice of naturopathy again in the State. The bill empowers the Executive Committee to suspend or revoke licenses of naturopaths reinstated under the provisions of the bill, under certain conditions. The Executive Committee has passed the following resolution:

"The question of the practice and operation of naturopathy in South Carolina, as well as in other states, has been thoroughly discussed in the legislative halls of this State, with the result that the law and amendments thereto permitting the practice of naturopathy in South Carolina have been repealed. It is felt that this action by the South Carolina Legislature was for the best interest of the people of the State.

"The Executive Committee of the State Board of Health, therefore, goes on record as endorsing this action by the Legislature, and opposing any proposed bill which would again permit the practice of naturopathy in South Carolina."

The Executive Committee has taken action on several matters affecting the health of the people which are of interest to the medical profession. Upon the recommendation of the Crippled Children's Technical Advisory Committee, the Executive Committee has approved that, due to a serious lack of funds for Crippled Children in South Carolina, burn cases will no longer be accepted until after they are healed. Any contractures resulting could later be handled by an orthopedic surgeon. The orthopedist will review cases and pass on acceptability.

Approval has also been given for one or two well-organized and staffed county health departments, in cooperation with and the approval of the local medical societies, to establish a demonstration nursing

home care program for the chronically ill and medically needy cases in these specific counties. It will be necessary for this group to work very closely with the staffs of the local hospitals, for one of the primary purposes of this demonstration will be to determine whether or not some of the many chronically ill patients now in the hospitals can be transferred back home, if reasonable nursing and medical care is provided.

Incidentally, additional general health funds have been provided by the federal government for these and other purposes. Other purposes might include in the fields of dietetics and nursing care, consultant services to many of our nursing homes which are now being operated by lay personnel. Some of the owners and operators have had the distinguished qualifications of having successfully operated a retail liquor store, or of a general contractor, or of other types of occupations.

The Committee has passed regulations governing organized camps. The Standards recommended by the National Sanitation Foundation for spray-type dishwashing machines have been approved and made a regulation of the State Board of Health. The Rules and Regulations Governing Milk and Milk Products have been revised to allow the sale of multiple-vitamin milk provided it is properly labeled and assayed at intervals. Additions have been made to the regulations on shellfish in order to safeguard more effectively the health of consumers of these products. The regulations governing the registration and certification of midwives in 1958 have been approved.

Upon the recommendation of the Hospital Advisory Council Licensing Committee, revisions have also been approved in the licensing standards of institutions.

For the fiscal year 1957-58, South Carolina was allocated a total of \$2,888,389.00 Hill-Burton funds (Public Laws 725 and 482), which is a grant-in-aid program for hospital and health center construction administered by the Board of Health. To date, three projects have been approved for 1958 funds. From previous allotments, nineteen current projects are under way. These nineteen projects will provide three completely new general hospitals (Chesterfield County Hospital, McClellan-Banks Hospital, and Kershaw County Hospital, with a chronic disease wing and outpatient department), five ancillary facilities or bed area additions to general hospitals (Aiken County Hospital, Marion Sims Memorial Hospital, Georgetown County Memorial Hospital, Berkeley County Hospital, and Spartanburg General Hospital), one completely new intensive treatment hospital and outpatient department (State Hospital), four new public health centers (Orangeburg, Clarendon, Florence, and Cherokee counties), one new mental health clinic (Spartanburg), one outpatient addition to a general hospital (Columbia Hospital), two chronic-disease wing additions (Marlboro County Hospital and Divine Saviour Hospital), one completely new nursing home

(Greenville County), and one chronic-disease wing addition and outpatient department to a general hospital (Conway Hospital). The Greenville Tuberculosis Hospital, an addition to Hampton County Memorial Hospital, Fairfield County Health Center, and Cherokee County Nurses' Home and Training School have been completed this year.

Under current federal legislation both Public Laws 725 and 482 will expire on June 30, 1959. The Hospital Advisory Council and the Executive Committee have formally adopted resolutions requesting an extension of these Laws for a minimum period of at least five years, and these resolutions have been transmitted to all South Carolina members of the U. S. Congress.

On an annual basis the State Board of Health licenses approximately 165 institutions, makes preliminary inspections of proposed institutions, and reviews plans for new construction.

As of February 4, 1958, there were ninety-five general hospitals, with 6,528 beds; six tuberculosis hospitals, with 1,008 beds; one EENT hospital (Anderson's E&E Clinic, Spartanburg), with four beds; one maternity hospital (Maternity Shelter Hospital, Greenville), with thirty beds; one orthopedic hospital (Shriner's Hospital for Crippled Children, Greenville), with sixty beds; one chronic hospital (South Carolina Convalescent Home, Florence), with forty-four beds; forty-three nursing homes, with 908 beds; and thirteen institutional infirmaries (colleges, children's homes, and correctional institutions), with 389 beds.

Influenza occurred in epidemic proportions in the late fall and early winter, with an estimate of well over 100,000 cases occurring in the State. Tests, largely from institutional populations, resulted in the finding of Asian strain influenza and indicated that the outbreak was due to this strain. In anticipation of this epidemic of world-wide significance, an Asian influenza vaccine was developed and manufactured in this country. At the end of the year only about a quarter of a million doses of the vaccine had been made available for South Carolina. The Executive Committee passed a resolution stating that the Asian influenza vaccine should be given by private physicians. The State Board of Health was authorized to carry out an informational program, giving the people pertinent facts about influenza and the Asian influenza vaccine. Physicians and county health departments in the State were kept informed as to the Asian influenza situation as information became available to the State Board of Health. Two hundred thousand folders giving information that would answer the majority of the questions people were asking regarding influenza and would inform them how they could secure the vaccine and how they could care for themselves were printed and distributed through physicians' offices and county health departments. Frequent bulletins were released to the newspapers, radio and television stations giving information pertinent to South Carolinians.

A sporadic localized epidemic of diphtheria occurred in Dorchester County, where it was found in this outbreak that only two of the thirty-two cases had had adequate immunization.

Three outbreaks in nursery populations in three different hospitals created a problem in determining control measures that were not fully answered during the year. In one hospital, there was an outbreak of some fifteen cases of meningitis caused by an organism yet unnamed. It is a serious problem, since the babies who contact it and do not die are left invalids. In two other hospitals in the State there were outbreaks of resistant *Staphylococcus* infections that cause impetigo and deeper abscesses in infants and breast abscesses in nursing mothers. At present there is no easy and ready means of control of these outbreaks.

The poliomyelitis vaccine program continued at a satisfactory rate, with 529,970 doses being given. It is estimated that more than 60% of the population under twenty years have had two or more doses, with the age group 5-14 years best protected. A total of 128 cases of polio, of whom sixty-seven were paralytic, were reported in 1957.

Forty-two counties participated in the insect control program in 1957. Insecticide concentrate and insecticide dust were used to treat residually 63,158 premises and space treat 149,246 acres. Twenty-seven cities and towns now have landfill methods of garbage disposal.

Rabies in animals, as measured by positive heads, declined to 147, and human treatments to 1407, both of which are the lowest figures since the initiation of the rabies control program.

Testimony by the Cancer Control Section has been given a special legislative committee on a State Nursing Home for terminal cancer patients. This committee is recommending to the General Assembly that it be continued for another year in order that its members can appear before the State Budget and Control Board in 1958 to make a definite request for funds to build and operate a 100-bed State Cancer Nursing Home during 1959-60.

The Tuberculosis Control Section maintains a complete case register, which now contains 6,065 cases of tuberculosis.

The two mobile photofluorographic units operated by the Section of Tuberculosis Control conducted mass x-ray surveys in twenty-five counties, in which 98,835 individuals were examined and 152 were found to have reinfection tuberculosis, and three with other forms of tuberculosis. Two hundred twenty-three were suspicious for tuberculosis. An additional 148 persons were found to have pulmonary scars and are not included in the above figures.

Each county is visited by the units every eighteen months or two years. The length of time allotted to a county is based on request. A schedule is prepared and each county is notified a year in advance of the time.

Because of much publicity relative to the genetic dangers associated with x-radiation, the Tuberculosis Control Section has taken every safeguard in operating its mobile and county x-ray equipment and has continued to emphasize the mass x-ray surveying of apparently well persons forty-five years of age and over. It has been observed that the danger from tuberculosis is far greater in all age groups than the theoretical danger of genetic mutations from chest x-rays.

Approximately twenty of the existing sixty-five shoe-fitting x-ray machines were discontinued during the year. A bill had been introduced by the entire delegation of Orangeburg County to discontinue the use of any type of fluoroscopic machine by unqualified persons.

An intensive education program has been carried out to enlighten the lay public in heart research and in the heart diseases through personal appearances before organized groups and through regular news releases.

By assigning technical personnel to the Peripheral Vascular Clinic and to the Lipo-protein Laboratory at the Medical College, it is felt that the Section of Heart Disease Control is making a contribution to their clinical and research studies in atherosclerosis.

A study is currently being made by the Venereal Disease Section to glean as much epidemiological and other information as possible pertaining to the problem of "gonorrhea repeaters"—patients who have been given what is considered adequate treatment, but who return for retreatment one or more times during a twelve-month period. As a technique for case-finding, a house-to-house collection of blood specimens for serological tests for syphilis in areas suspected or previously proven to be of high syphilis incidence has been undertaken. This has been more productive in uncovering hidden cases than the mass blood testing program of a few years ago. Cluster testing is a step further in the epidemiology of syphilis by which means the contacts sought are not limited to those named by the patient. A 30-hour VD institute for nurses and other field personnel was conducted during December.

The State Laboratory made a grand total of 352,348 tests and examinations, with an additional 25,819 tests and examinations being performed by the four district laboratories located at Anderson, Florence, Spartanburg, and Walterboro. These laboratory services were provided to health departments, hospitals, clinics, and private physicians to aid in the diagnosis, prevention, and control of diseases that are of public health significance.

In maternity care, 1,846 prenatal clinic sessions were held by physicians, with 5,421 new patients registered. The 1,029 certified midwives who last year delivered 17% of the 63,520 babies born in the State were supervised, and in many instances trained. Regularly scheduled child health clinics as well as pre-school clinics were held for examination and inoculation of children, and for guidance to parents

on child care.

Special studies on infant and maternal mortality have been carried out, and special reports are being made on these through the Maternal Welfare, and Infant and Child Health Committees. In cooperation with the State chapter of the American Academy of Pediatrics, a poison control center for state-wide use has been opened at the emergency room of the Columbia Hospital, where there is 24-hour service available to answer queries from physicians and hospitals over the State as to ingredients and treatment for the many poisons now on the market in the form of household supplies, insecticides, and the like.

The Maternal Welfare, the Infant and Child Health, and the School Health Committees of the South Carolina Medical Association act as technical advisory committees to the Maternal and Child Health Division's programs.

Through special funds appropriated by Congress, an evaluation clinic for mentally retarded children under seven from over the whole State has been opened in the Pediatrics Department of the South Carolina Medical College Hospital. This program has been developed by the Maternal and Child Health Division.

The Crippled Children's Division has continued its regular diagnostic and treatment services through its clinic, hospitalization, convalescent home, and appliance programs. Due to the fact that more children have been hospitalized, hospital costs have greatly increased, and no additional federal or State funds are available, the Division will have to curtail materially hospitalization expenditures before the end of the fiscal year. It is of interest to note that the register for crippled children of the State Board of Health includes some 5,447 names; and since a child is registered only if he meets the definition of a crippled child as determined by orthopedists and pediatricians, certainly most of these must be in need of some type of medical or surgical care.

The rheumatic fever case load has continued to increase, especially in the Greenville area, since the establishment of the rheumatic fever clinics in Columbia and Greenville two years ago.

The Division of Sanitary Engineering has reviewed all plans and specifications for proposed construction of new treatment works and additions to existing water and sewage treatment facilities; maintained contact with all sewage and water personnel over the State; made supervisory inspections of operating practices; monitored all bacteriological reports; made routine inspections and certifications of all water systems supplying interstate carriers; approved plans for construction of all quasi-public and public artificial swimming pools; and processed forms necessary to assure Federal Housing Administration, Veterans Administration, and such other home loan insuring agencies that methods proposed for water supply and sewage disposal will meet approval or disapproval of the State Board of Health.

During the year important conferences were conducted with county sanitarians and representative persons from all industries interested in food processing for the purpose of establishing a more wholesome cooperative relationship.

Inspections have been made to control all aspects of sanitation in bedding manufacturing plants, bedding renovators, and places of storage which contain filling material and finished products for sale.

Foodhandlers' schools have been conducted on request. This Division handles the sanitation of milk and milk products, retail food sale, shellfish, frozen dairy foods, frozen desserts, bottling plants, bakeries, canneries, salad kitchens, and poultry processing plants.

The Water Pollution Control Authority, although operating under separate State and federal appropriated funds, is fast becoming an integrated activity. Close cooperation has been maintained between engineering personnel in the Division of Sanitary Engineering and the Water Pollution Control Authority.

The chief function of the Division of Local Health Services is to coordinate and equalize the demands upon local health departments by the various divisions and sections of the central office, so that each county will be carrying on a well-balanced program. All county personnel work under the technical supervision of the director of this division.

At the present time there are eight counties without health officers. In these counties an administrative assistant has been appointed to have administrative responsibility for property, supplies, etc., the signing of official communications, and serve as liaison with the county delegation and with organizations and the public in matters concerned with public relations. In three of the eight counties the administrator is able to carry all these responsibilities with a minimum of assistance; however, in the remaining five counties the Director of Local Health Service has had to deal directly with the county delegations in the preparation of budgets and other administrative matters and, in fact, serve as acting health officer. The remainder of the health departments are served by twenty-three full-time and five part-time health officers. There are nine bi-county units, one tri-county unit, and the remainder are single units. The tri-county unit is served by one full-time health officer. Each of the bi-county units has a full-time health officer, and the remainder are served by a single full-time health officer or a part-time health officer exclusive of the eight which at the present time do not have the service of a health officer. The county staffs consist of approximately 186 public health nurses, ninety-five sanitarians, and 114 full-time clerks.

We have been unable to employ a full-time health officer since July 1, 1951. One of our full-time health officers is now 77, one 74, one 71, one 70, and one part-time health officer is 78. In addition, five of the full-time and one part-time health officer are between

64 and 70 years of age. On the basis of the above, it readily can be seen that during the past year the greatest need of the Division of Local Health Services was for trained full-time health officers with which to supply counties in need of this essential service.

The towns of Marion and Darlington have begun fluoridating their public water supplies this year. The fluoridation of community water supplies, endorsed by the Executive Committee, has been advocated and promoted by the Dental Division. The "Little Jack" mouth health puppet show has continued to play fifteen different schools each week in different counties during the school year as a major dental health education project of the State Board of Health. National Children's Dental Health Week was observed during the week of February 2-8, 1958, with appropriate educational methods. Two dental hygienists have been added to the Dental Division—one assigned to the sodium fluoride demonstration team and the other to work in the educational field.

The Bureau of Vital Statistics during the current fiscal year placed in effect a new program for the collection of birth, fetal death, and death certificates which requires that the certificates be routed through the county health departments, where they are checked for accuracy and completeness before forwarding on for filing to the Bureau of Vital Statistics each month. Records are photostated and the photostatic copies, approximately 12,000 each month, are shipped to the counties for filing. This revised program discontinued the system of local registrars.

In addition to this new program, the Bureau currently registers and permanently houses approximately 132,500 vital records annually. Of these, approximately 19,000 are deaths, 1,500 fetal deaths, 64,000 births, and 48,000 marriages. This provides a ratio of 3.5 births to each death. Permanent records are being microfilmed. Counties can obtain copies of the microfilm for their respective counties, providing an accurate copy of the original record at the local level from January 1, 1915.

The Bureau files approximately 6,500 delayed records of birth per year, and corrects approximately 15,000 certificates per year, as a result of errors on original records. In its statistical program unusual progress has been made since 1945, when compilation of statistical data required only 42 printed pages, as compared with 544 pages in the current year.

As of July 1, 1957, there were 839 persons employed by the State Board of Health. In accordance with action taken by the 1957 General Assembly, salary increases were provided employees at the beginning of the fiscal year. The Compensation Plan (salary schedule) was revised, and approved by the Executive Committee, the Merit System Council, and the U. S. Public Health Service. The majority of central office salaries now conform and the county health departments have been requested to bring their employees' salaries into proper steps as rapidly as funds become available.

Health education activities have included technical services and consultation to public health workers, organizations, and individuals on educational methods and audio-visual aids and materials. Health talks and discussions have been a part of the program as well as the preparation of exhibits; regular news releases; the publication of reports, pamphlets, folders, a monthly news letter; the maintenance of an information service; weekly radio and television programs; the preparation and distribution of photographs and slides; the processing of 2,271 films in the film library, viewed by 130,805 individuals on a free loan basis; the production of materials and forms by duplicating processes; and participation in in-service education programs, conferences, institutes, and workshops. A major accomplishment during the past year was the preparation of a State Board of Health Record Manual, which included copies of all record forms used by the county health departments, each form being accompanied by an instruction sheet giving information about the purpose, explanation and office mechanics of the form.

The Tabulating Unit through the use of punch cards and electronic I. B. M. tabulating machines has contributed to general efficient administration of public health work by providing quickly and accurately tabulations necessary to the operation of the State Board of Health.

The employment of the Drug Inspector on a full-time basis last year has been more than justified as evidenced by the large number of violators of the barbiturate and narcotic laws he has discovered and brought to trial. His work has been closely associated with federal agents who are enforcing the Federal Narcotic Act. For the purposes of clarification only it should be stated that the Harrison Narcotic Act is a federal act whereas the Uniform Narcotic Act is a State act. To understand the necessity of the two acts and when to apply one and not the other, it is necessary to furnish some historical and factual background.

The Congress of the United States enacted legislation restricting the use of narcotic drugs to medicinal purposes only in 1912, making the violation of the Act a criminal offense. The Supreme Court of the United States invalidated the Act as being unconstitutional.

The Harrison Narcotic Act was enacted by Congress in 1914, with the effective date being January 1, 1915. The new act was primarily a revenue act, thereby avoiding the constitutional question in the original act. The Harrison Act was declared constitutional and has been in effect since 1915.

Immediately thereafter, all states were urged to enact what is known as the State Uniform Narcotic Act, which is basically a criminal act, in order to coordinate State enforcement with the federal enforcement. South Carolina was one of the first states to enact this legislation. The State Board of Health was charged with the enforcement of the Act; however, no provision was made by the General Assembly

for this enforcement until within the past few years.

To become registered under the federal act to professionally use narcotic drugs, the applicant must be certified as being "Licensed by the State to practice his profession, and be authorized under the laws of the State to handle narcotic drugs." Otherwise, the Federal Internal Revenue Service may not issue the Narcotic Tax Stamp.

In view of the fact that the State licenses the registrant professionally, it is desirous that the State supervise the enforcement of the Narcotic Act insofar as minor violations are concerned, in which no violation of the Revenue Code is involved.

Obtaining narcotic drugs by fraud and deceit, such as the issuing of false prescriptions, the giving of a false name and address, the withholding of a material fact, subterfuge, etc., are criminal acts within the meaning of the State Act, and do not necessarily involve revenue violations, and such violations are referred to the State courts for prosecution.

In the event a registrant is found to be diverting narcotics to his own use for gratification of addiction, the State, in cooperation with the federal authorities, investigates. If no evidence of sale is discovered, the registrant is permitted to voluntarily surrender his Tax Stamp and discontinue handling narcotics in lieu of prosecution.

In the event a registrant or other person is found to be trafficking in narcotics, the selling of untaxed narcotics or the interstate trafficking in narcotics, the violation is referred to the federal courts for prosecution.

In 1956, the Congress of the United States instructed the Federal Bureau of Narcotics to coordinate and cooperate with the State enforcement agencies in the carrying out of all laws pertaining to narcotic drugs.

Funds for the operation of public health work in South Carolina have been derived from federal, State, and local sources. During the past few years there has been a continuing decrease in the amount of federal allocations for health, which has necessitated increased appropriations by the South Carolina General Assembly. Relations with this group have been on a most cooperative basis, and the State is assuming more and more financial responsibility for public health programs, which we feel is good. We do not mean to imply that the federal government has decreased appropriations for health. In reality, the appropriations have been markedly increased. The difference should be expressed that direct health services are being decreased, whereas in the field of research there has been an outstanding increase. The State has been compensating in the field of direct services. We feel that these changes are healthy, and more in line with national medical thinking.

The total funds from all sources, federal, State, and local, expended through the State Board of Health during the past fiscal year ending June 30, 1957, amounted to \$7,657,290.52, as follows: Hill-Burton

Hospital Construction funds, \$1,536,204.34; Local, State, and Federal Health Services, \$5,125,986.18; and Water Pollution Control Authority federal funds \$995,100.00.

W. R. Wallace, Chairman

REPORT OF MEMORIAL COMMITTEE—1957-58 SOUTH CAROLINA MEDICAL ASSOCIATION

In the midst of life's rush and hurry we pause to remember each member of the South Carolina Medical Association who passed away during the year and

it is with a saddened heart that your Memorial Committee list the following in Necrology with this prayer: "O Merciful God, whose mercies cannot be numbered; Accept our prayers on behalf of the souls of thy servants departed, and grant them an entrance into the land of light and joy, in the fellowship of thy saints; through Jesus Christ our Lord." Amen

Respectfully submitted:

William H. Folk, Chairman

W. A. Smith

Lonita Boggs

HUGHES—FUNCTIONAL ILLNESS

(Continued from Page 109)

should only be referred to psychiatrists if they fail to respond to combined medical treatment and psychotherapy on the doctor-patient level.

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NECROLOGY 1957-58 — SOUTH CAROLINA MEDICAL ASSOCIATION

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HOWARD M. WALKER, M. D. Spartanburg, South Carolina	1898-1957	U. of Texas — Class 1921 Radiologist
SAMUEL E. WHEELER, M. D. Columbia, South Carolina	1890-1957	Medical College of S. C. (Class of 1913)
EUGENE MOOD WILLIAMS, M. D. Lake City, South Carolina	1888-1957	Medical College of S. C. (Class of 1910)



Ocean Forest Hotel, Myrtle Beach, Headquarters

Exhibitors Pages

G. D. SEARLE & CO. Chicago, Illinois

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Enovid, the new synthetic steroid for treatment of various menstrual disorders; Zanchol, a new biliary abstergent; Nilevar, the new anabolic agent, and Rolicton, a new safe, non-mercurial oral diuretic.

Also featured, will be Vallestiril, the new synthetic estrogen with extremely low incidence of side reactions; Pro-Banthine, the standard in anti-cholinergic therapy; and Dramamine, for the prevention and treatment of motion sickness and other nauseas.

PARKE, DAVIS & COMPANY

Medical service members of our staff will be in attendance at our exhibit to discuss important Parke-Davis specialties which will be on display.

PET MILK COMPANY

We will be pleased to have you stop and discuss the variety of time-saving material available to busy physicians. Our representatives will be on hand to discuss the merits of "Pet" Evaporated Milk for infant feeding and "Pet" INSTANT Nonfat Dry Milk

for special diets. A miniature "Pet" Evaporated Milk can will be given to all visitors.

THE WM. S. MERRELL COMPANY

Quiactin for quieting . . . an improvement over present tranquilizers for tension—anxiety states; patients remain alert, feel better, and TACE, a "treatment of choice" for suppression of lactation will be featured.

You are invited to discuss these and other Merrell research products with our representatives.

WM. P. POYTHRESS & COMPANY, INC. Richmond, Va.

A cordial welcome awaits members at the Poythress booth. Solfoton and its companion products, Antrocol and Solfoserpine, will be featured. Also featured will be Mudrane, outstanding Poythress antiasthmatic drug; Trocinate, Poythress' distinctive antispasmodic; Panalgiesic, leading ethical local analgesic and counter-irritant; and other well-known Poythress specialty products. Requests for trial supplies or literature on these drugs will be welcomed.

THE STUART COMPANY

Your local Stuart representatives invite you to stop by and see three new Stuart products. These new

products are Bucladin, a new combined antiemetic and antinauseant in a unusual tablet form; and Stuart Prolar and Prolar-B, two new non-narcotic analgesics with a number of interesting advantages.

J. B. ROERIC AND COMPANY

J. B. ROERIC AND COMPANY, booth #33, will feature ATARAX, the new "Peace of Mind" drug. It's an all new chemical and is especially indicated for the "more normal" person, to bring relief from the common everyday tensions and anxieties. Co-featured with ATARAX will be BONADOXIN, the anti-emetic for relief of the nausea and vomiting of pregnancy; also effective in postanesthetic nausea and postradiation sickness. Literature and samples are available to physicians at the booth which you and your friends are cordially invited to visit.

ABBOTT LABORATORIES

Abbott Laboratories will welcome members of the medical profession at the company's exhibit of leading specialties and new products. Representatives will be in attendance to answer any questions you may have. Abbott recently introduced a number of new products which representatives at the exhibit will describe and give information on the results of clinical reports.

FEDERAL FINANCIAL RECOVERY SERVICE, INCORPORATED Fayetteville, N. C.

This organization renders a credit control and collection service. Our service operates on a membership plan where we do all the work, furnish all supplies including paying for the postage. All money is paid direct to you at a net cost of 10% on actual amount recovered. We do not, at any time, handle your money.

We are equipped to recover your accounts wherever they may be located since we are a national organization. We represent thousands of clients in your field.

LEDERLE LABORATORIES DIVISION

You are cordially invited to visit the Lederle booth where our Medical representatives will be in attendance to provide the latest information and literature available on our line. Featured will be Achromycin V, Vitamins, Aristocort, and many other of our dependable quality products.

THE COLUMBIA BRACE SHOP

The Columbia Brace Shop will exhibit a line of braces and other orthopedic appliances.

ELI LILLY AND COMPANY

You are cordially invited to visit the Lilly exhibit located in space number 9. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

The following Lilly salesmen and field manager

will be in attendance at our exhibit during the meeting.

Mr. W. B. Watts (in charge of exhibit)
Mr. E. L. Bunn, Jr.
Mr. J. R. Smith

THE S. E. MASSENGILL COMPANY

Best wishes from Massengill to the members of South Carolina Medical Association for a most successful and informative meeting! Should you so desire, capable Massengill representatives would be pleased to discuss with you any Massengill products in which you are interested. Products being featured are Adrenosem (the unique systemic hemostat); Homagenets (the only solid homogenized vitamins); Obedin (superior weight reducing aid); The Salcort Family (offering a complete range in arthritic therapy); Saferon (the peptonized iron); Massengill Powder (the douche preparation of choice). If you wish them, literature and samples will be available.

GEIGY

The GEIGY exhibit will feature BUTAZOLIDIN and BUTAZOLIDIN-ALKA, potent non-hormonal anti-arthritis and anti-inflammatory agent also effective in the treatment of superficial thrombophlebitis; and PRELUDIN, non-amphetamine appetite suppressant virtually without CNS stimulation. Also on display will be STEROSAN HYDRO-CORTISONE Cream and Ointment, for comprehensive control of a wider range of dermatoses; MEDOMIN, the hypnotic which provides "natural" sleep; and SINTROM, potent oral anticoagulant with intermediate duration of action.

TABLE ROCK LABORATORIES, INC.

Table Rock Laboratories takes genuine pride in presenting SEDALGESIC, a non-narcotic, non-barbiturate analgesic and sedative for pain associated with emotional stress. SEDALGESIC produces rapid and sustained relief and because it can only be dispensed on prescription there is no possibility of use abuse. Clinical evidence proves that SEDALGESIC is worthy to take its place among the other proven Table Rock specialties, which include BISMUTH VIOLET, TABOREA, DILOCOL, TA-VERM, RAUJA and SENAZOL.

WINCHESTER SURGICAL SUPPLY CO.

We invite you to visit our exhibit No. 36 where you will see the latest in Surgical Supplies on display:

BY CAROLINAS' HOUSE OF SERVICE
WHERE SATISFACTION IS GUARANTEED
QUALITY — DEPENDABILITY — SERVICE

Emory L. Floyd, Tom Coble and R. M. Conder will be there to greet you.

CAMBRIDGE PHARMACEUTICALS

Cambridge Pharmaceuticals, Inc. Booth Number 32 will exhibit Gynben, a vaginal insert designed for treatment of Monilia, Trichomonas, and non-specific Vaginitis (bacterial). Also on Display will be the group of Rauwolfia drugs: TSR-100 and Raumantal.

A. H. ROBINS COMPANY, INC.

Richmond, Virginia

The A. H. Robins exhibit spotlights DIMETANE, the new and unexcelled antihistamine (available in Tablets, Elixir and long-acting Extentabs), and ROBAXIN, the important new skeletal muscle relaxant, synthesized in the Robins Research Laboratories.

Representatives in attendance at the booth will also be happy to discuss the therapeutic advantages of ALLBEE with C, AMBAR and DONNATAL PLUS or other Robins prescription items.

VANPELT & BROWN, INCORPORATED

Richmond, Virginia

VanPelt and Brown extend a cordial invitation to visit their exhibit where representatives will be happy to answer questions and supply clinical samples of their products.

DRUG SPECIALTIES, INC.

Drug Specialties, Inc. will feature in its booth at the South Carolina Medical Meeting at Myrtle Beach in May, Nicozol (a cerebral stimulant and tonic for the aged) and Nicozol with Reserpine (an analeptic tranquilizer).

MAYRAND, INC.

Greensboro, N. C.

We plan to present a booth emphasizing our product "Antora Capsules" and "Antora B Capsules" primarily used in treating Angina Pectoris patients.

There will be a representative with our booth to introduce the product to the guests with samples of the products. There will be a few side-line products displayed as an added incentive.

WACHTEL'S PHYSICIAN SUPPLY CO.

We plan to exhibit many items of interest such as the Burdick latest model EKG, Ultrasonic, and their new Telecor Cardiac Monitor. We will also have diagnostic instruments of various kinds, surgical instruments, etc.

We cordially invite all attending this meeting to pay a visit to our booth.

MEAD JOHNSON & COMPANY

The Mead Johnson exhibit (Booth No. 43) has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be

on duty to tell you about their products.

A. S. ALOE COMPANY

The Aloe Company plans to exhibit its Steeline Examining Room Equipment, New Line of Swedish Steel Instruments, Disposable Examining Gloves, as well as other equipment and disposable items which are exclusives with our company.

CHARLES C. HASKELL & COMPANY

Richmond, Virginia

Representative will be present to welcome visiting physicians and to answer any inquiries regarding our ethical prescription specialties, such as our BELBARB family (sedative-spasmolytic), HASAMAL-HASACODE (analgesic), IROSUL-C (hematinic with vitamin C), PANTABEEROID (thyroid therapy), and other rational therapeutic combinations. In addition to the Haskell products we will have from the Amar-Stone Laboratories, Inc., AMERICAINE TOPICAL ANESTHETIC OINTMENT and AEROSOL, and SILICOTE SKIN PROTECTIVE OINTMENT and LIQUID SPRAY.

MERCK SHARP & DOHME

A new and very promising diuretic is featured at the Merck Sharp & Dohme booth. Since the principal action of 'DIURIL' is a marked enhancement of the excretion of sodium, chloride and water, it has been designated a saluretic agent. This new compound achieves a profound electrolyte and water diuresis without attendant toxic effects and other disadvantages peculiar to the mercurials and certain other diuretic agents.

Technically trained personnel will be present to discuss this and other subjects of clinical interest.

WESTWOOD PHARMACEUTICALS

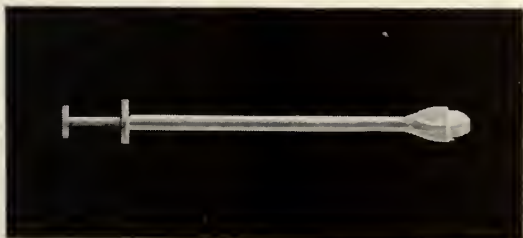
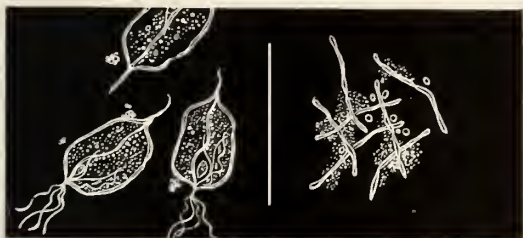
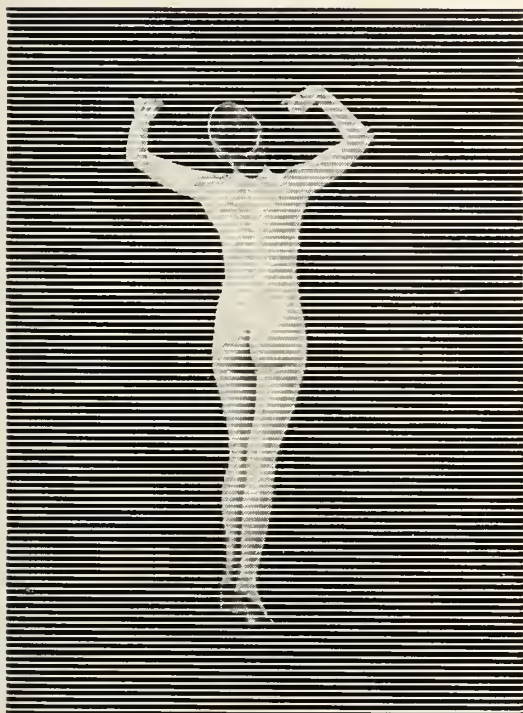
FOSTEX CREAM and FOSTEX CAKE are new, easy to use therapeutically effective medications for the treatment of acne, dandruff and seborrheic dermatitis. They contain Sebulytic[®] (lauryl sulfoacetate, alkyl aryl polyether sulfonate, and dioctyl sulfosuccinate) a unique combination of penetrating anionic soapless cleansers and wetting agents which are highly antiseborrheic and exert antibacterial and keratolytic effects . . . enhanced by sulfur, salicylic acid and hexachlorophene.

Fostex Cream is applied as a therapeutic skin wash in the initial treatment of acne, when maximum degreasing and peeling are desired. Fostex Cake is used as a therapeutic skin wash for maintenance therapy to keep the skin dry and substantially free of comedones. Fostex Cream is also used as a therapeutic shampoo in dandruff.

(More)

Floraquin®

Destroys Vaginal Parasites Protects Vaginal Mucosa



Vaginal discharge is one of the most common and most troublesome complaints met in practice. Trichomoniasis and monilial vaginitis, by far the most common causes of leukorrhea, are often the most difficult to control. Unless the normal acid secretions are restored and the protective Döderlein bacilli return, the infection usually persists.

Through the direct chemotherapeutic action of its Diodoquin® (diiodohydroxyquin, U.S.P.) content, Floraquin effectively eliminates both trichomonal and monilial infections. Floraquin also contains boric acid and dextrose to restore the physiologic acid pH and provide nutriment which favors regrowth of the normal flora.

Method of Use

The following therapeutic procedure is suggested: One or two tablets are inserted by the patient each night and each morning; treatment is continued for four to eight weeks.

Intravaginal Applicator for Improved Treatment of Vaginitis

This smooth, unbreakable, plastic device is designed for simplified vaginal insertion of Floraquin tablets by the patient. It places tablets in the fornices and thus assures coating of the entire vaginal mucosa as the tablets disintegrate.

A Floraquin applicator is supplied with each box of 50 tablets. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

SEARLE

ZIMMER-BAXTER

Zimmer-Baxter Associates of Charlotte, North Carolina, Exclusive Distributors for Zimmer products in South Carolina will be on hand to welcome the members of the South Carolina Medical Association in Booth No. 1 during the annual convention at Myrtle Beach. Many new Orthopaedic and fracture items will be available for your inspection.

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A visit to the Warner-Chilcott booth will be well worth while, especially in the interests of your cardiovascular patients, and those with mental or emotional disturbance. The booth features two clinically tested and proven agents: *Peritrate*—to aid you in the management of patients with angina pectoris; and *Pacatal*—a profound ataractic agent with a "normalizing" action.

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1. Qualification for membership in the A. M. A. and access to its advantages.
2. Subscription to the Journal of the South Carolina Medical Association, access to its scientific articles and opportunity to contribute.
3. Opportunity to participate in important phases of the State Government:
 - (a) Board of Health (nearly identical with State Association).
 - (b) Hospital Advisory Commission.
 - (c) Board of Medical Examiners.
 - (d) Board of Examination and Registration of Nurses.
 - (e) State Industrial Commission (arrangement of fee schedules).
4. Means of participation in promoting best interests of the profession:
 - (a) Upholding its high standards.
 - (b) Protection from legislative restriction.
 - (c) Co-operation in support of legislation in the public interest.
5. Listing in the Directory—issued biannually.
6. Access to information on current scientific developments in the field of medicine and surgery through scientific sessions of State Association and the affiliated specialty groups.
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9. Opportunity for contacts with fellow-members of

the profession in other parts of the State and for enjoyment of the fellowship of the annual meeting.

10. The satisfaction of having a part in the united effort of a high-type group of individuals in contributing to the promotion of the public welfare.

MEMBERSHIP IN THE A. M. A.

"From time to time interested observers ask: What does a physician gain by being a member of the American Medical Association? It would be impossible to answer this question in the confines of any brief statement. The issue of THE JOURNAL that contains the reports to the House of Delegates provides details on the many offices that make up the Association and that serve the medical profession and the nation. In fact, this service is reflected far beyond the boundaries of the United States, as many people in other countries follow the activities of the American Medical Association and put into practical application some of its findings and recommendations The reports show what the Board of Trustees, the Secretary, the Publications Dept., the Washington Office, the P. R. Dept., the scientific councils and the many other councils, committees and bureaus do during the course of a year. Whether the reader is interested in medical education, voluntary insurance plans, the development of a scientific program, or health education, he can find information on what the Association is doing in these and other fields by referring to this issue of THE JOURNAL

"Thus, when one asks, 'What do I get for my dues?' he must not expect a brief explanation. The work of the Association cannot be described briefly. Any one department, if used fully by the member, will more than repay him for the small amount of money spent in dues. For example, to choose just one department: The Bureau of Legal Medicine and Legislation provides information on, among other things, partnership agreements; hospital records—medicolegal aspects; income taxes; malpractice; medical practice acts; cults; expert testimony; trauma and disease; privileged communications; coroner and medical examiner systems; blood-grouping tests in disputed parentage; chemical tests for intoxication—legal aspects; workmen's compensation and occupational disease legislation; legisla-



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tion of medical interest—federal and state; basic science laws; premarital and prenatal examination laws; roentgenograms—ownership; confidential communications; autopsies—consent; operations—consent; sterilization operations, artificial insemination; birth control—legal aspects; Constitution and By-Laws; and food and drug legislation. The Washington Office, as another example, provides information on federal legislation on health, bulletins on legislative matters, and copies of specific bills.”

(Extract from Editorial, Journal, A.M.A., January 6, 1951.)

OPTOMETRY DEFINED

It has been stated on many occasions that, as a rule, physicians are not able to differentiate between ophthalmology and optometry. Some physicians are content to take the position that the subject is equivocal, thereby assuming an attitude of total indifference; others equate ophthalmology with optometry, thus jeopardizing the visual welfare of their patients; another group looks disdainfully upon optometry, considering it a sort of a cult or sect, whose members are constantly resorting to pressure tactics in their quest for a short-cut to medicine, a privilege denied them by reason of their own inadequacies.

To assume any one of these positions is not consistent with the spirit of medicine, the inalienable rights of the optometrist, or the personal dignity of the physician. Optometry is a legalized “profession” and we should accept it as such, even though the term “profession” seems to suffer so, in the face of its practical application to department store, jewelry store and cut-price eye glass emporium optometry. In view of the existing conflict of opinions relative to the scope and sphere of optometry, the committee prefers to define optometry as it is defined by Pennsylvania law:

“The practice of optometry is hereby defined to be the employment of any means or methods, other than the use of drugs or surgery, for the examination of the human eye and the analysis of ocular functions, or the prescribing, providing, furnishing, adapting or employing any or all kinds and types of lenses and prisms, visual training orthoptics, ocular exercises, and any and all preventive and corrective methods for the aid, correction or relief of the human eye, its associated structures, appendages and functions, other than the use of drugs or surgery.” (Purdon’s “Pennsylvania Laws”).

Therefore, it is most evident that Pennsylvania law never intended to equate optometry with ophthalmology.

The lawmakers recognized the fact that ophthalmology is concerned with the medical or surgical care and management of every phase of ocular or visual derangements and their intimate association or relationship to all other bodily functions, whereas optometry, by reason of special restrictive legislation and enactments, is permitted to function in a small

segment of the whole field of ophthalmology, a segment so minute and relatively unimportant that optometry cannot even claim exclusive rights to it. Ocular abnormalities, either as a cause or effect of systemic abnormalities, do not by any stretch of any one’s imagination fall under the purview of optometry.

Optometry is primarily concerned for its very existence with the prescribing, furnishing, adapting, manufacturing and employing any and all kinds of lenses, prisms, exercises, etc., when such aids will alter or ameliorate an existing non-pathologic visual abnormality. Refractive errors are not pathologic entities. Spectacle lenses have never controlled or contained the progress of ocular pathology.

Pennsylvania law realized this fact and imposed additional restrictions on optometry by the enactment of the following restrictive legislation:

“Nothing in this act shall be construed as conferring on the holder of any certificate of licensure issued by said board the title of doctor, oculist, ophthalmologist, or any other word or abbreviation indicating that he is engaged in the practice of medicine or surgery, or the treatment or diagnosis of diseases or injuries to the human eye, or the right to use drugs or medicines in any form for the treatment or examination of the human eye. The title ‘Doctor’ or the abbreviation ‘Dr.’ shall not be used before the name of any registered optometrist without the word ‘optometrist’ following the name.” (1917, March 30, P.L. 21, pp. 11; 1925, May 13, P.L. 569, pp. 3.)

Doctor, the answer to the riddle is simple—optometry can never hope to attain the heights of ophthalmology unless YOU make it so.

Reprinted from the PHILADELPHIA MEDICINE, Vol. 53, No. 17.

BOOK REVIEW

PROGRESS IN GYNECOLOGY—Vol. III, J. V. Meigs and S. H. Sturgis, Editors. Grune & Stratton, New York 1957. Price \$15.50.

This is not another edition but a supplement to Volume II published 5 years ago. Together with Volumes I and II and with Meigs’ “Surgical Treatment of Carcinoma of the Cervix” the four volumes constitute a good detailed study of both basic gynecology and the advances of the last eleven years.

Volume III covers basic science, diagnosis, endocrine gynecology, sterility, infections, tumors, and surgical techniques. A few of the articles are simply a rehash of old material and a few seem wholly impractical. But most of those on endocrinology, malignancy and pelvic plastic work are excellent, although the reviewer disagrees strongly with some of the last group.

It is an excellent book for the general surgeon in the average South Carolina town who does any amount of gynecologic work.

James M. Wilson, M. D.

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RADICAL SURGICAL TREATMENT OF BREAST CANCER

JEROME A. URBAN, M. D.
New York, N. Y.

My talk today will go along the same lines as Dr. Parker has brought out in his talk on cancer of the lung; essentially, that without early diagnosis and early detection, surgery or whatever local therapy might be contemplated, is usually not very effective. We believe firmly that in breast cancer particularly, a combination of early diagnosis and early, more thorough treatment, will increase the salvage rate.

In this first slide, as you see, the 5-year salvage rate in most of the clinics in the country is about 55 per cent with primary operable breast cancer treated by radical mastectomy and supplementary x-ray therapy. Now, that is twice the salvage rate that Halstead first reported in 1907. And the main reason for the improvement is that we are getting earlier cases and treating them before they have systemic disease. We are doing essentially the same operation. As you see, we have a fairly good salvage rate, but in 10 years this drops to about a third of the original number treated.

Now you don't get this kind of salvage rate with this sort of so-called radical. We get patients like the one in this slide at Memorial, and I am sure you do down here, who are sent in for x-ray therapy with a note saying the patient had a radical mastectomy and actually

they haven't even had an adequate simple mastectomy. This is a sad operation with thick flaps, no axillary dissection, a local recurrence in the incision, and is certainly to be condemned.

The patient shown in this slide has more like what we would represent as a typical post-radical condition, with thin flaps, careful axillary dissection, with the vessels apparent beneath the skin in the axillae. This is the sort of operation that you must do if you would anticipate a 55 per cent salvage in the average operable breast cancer.

I think everyone is in agreement that the one factor which influences your salvage rate most is the extent of disease at the time you operate on a patient. And this slide shows it pretty clearly. The salvage rate drops as the disease extends from the breast to the lower axilla, mid-axilla, and apex. It is just what you would expect. This indicates to me that we have to strive constantly to pick up the early cases. It is not easy to pick up the early case. We have to suspect every mass in the breast until we prove it is not carcinoma.

We were interested in checking up on our diagnostic acumen and were very sad to find that we didn't have any great degree of it. When we checked over 1500 patients who were sent into the hospital for a local excision with a benign or undetermined clinical diagnosis, eleven per cent of these patients proved to have carcinoma. But, actually, this is the

only way to pick up the early breast cancer. In its early stage, breast cancer doesn't have the pathognomonic signs usually attributed to it, such as skin dimpling, nodes in the axilla, nipple retraction, etc. It is just a little thickening or a mass in the breast. If you have a lesion that doesn't go away after a menstrual period, regardless of how benign you think it is, it is a good idea to take it out.

Now here are two illustrations of how misleading the clinical appearance can be. Here is an intraductile papiloma protruding through a duct opening in the nipple. Here is another one that looks very much like it but which is Paget's disease.

This is a pretty typical eczema and the next, also, looks pretty typical for eczema. This is Paget's disease as well. You simply cannot diagnose the early case without biopsy.

Anyone who sticks his neck out and prides himself on his diagnostic ability regarding breast cancer is a darned fool. He can pick up the late cases, but anybody can do that. The early cases cannot be detected without biopsy.

Now, can you really prove that these early cases are more salvageable? I think one can. Here are 800 cases which were treated by radical mastectomy. We divided them into 2 groups, the one group which was diagnosed clinically as having carcinoma, and the other group which we thought were benign in which we did local excisions, and found cancer. As you see, in the first group our 5-year salvage was 49 per cent and in the group which we thought was benign, but had cancer, and in which we did a radical, it was 74 per cent, which is about what we can anticipate if we pick up the early cases. If you look at the 5-year "free of disease" figures, the difference is even more striking: 42 per cent, and 69 per cent. We do not include in this last category 7 cases of non-infiltrating carcinoma since they are really "pathological" cancers and not clinical cancers. We had 100 per cent 5-year salvage in those patients. Now, it would be ideal to find breast cancers at this stage, but it is just impossible to pick them up except accidentally. As far as I am concerned, the most important factor in increasing our salvage rate in breast cancer is to get the lesions early. It isn't easy to find them early, you must do a lot

of local excisions in order to pick up the few cases that will appear as benign lesions but which are really early cancers.

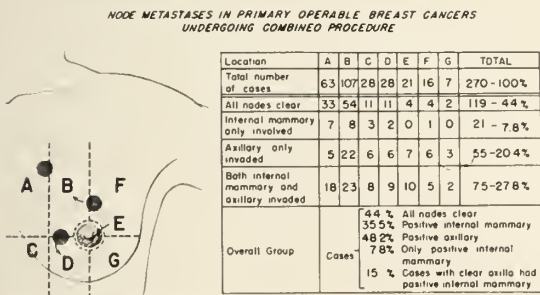
Even though we like to get the early cases, I don't think we can neglect the locally advanced case. Some individuals would consider the lesion in this slide inoperable because it shows ulceration, edema of the breast, and large nodes in the axilla. On x-ray survey of this patient, there was no evidence of systemic metastases. The neck was clear. We did a radical mastectomy, after examining this lesion by aspiration biopsy. This patient (slide) was operated on 9 years ago, and she is free of disease at present. She proved to have a large adenocarcinoma with inflammatory node enlargement in the axilla—all the nodes were negative inflammatory nodes. But, she fits in the classification of so-called categorically inoperable carcinoma of the breast according to some people. I believe that if there is no evidence of distant metastases and one can remove the disease locally, it is worth while doing it.

During the last 10 years there have been several schools of thought developing as to how we can improve on the radical mastectomy procedure. And the background of each is based on the natural history of breast cancer. I think everyone agrees that in the early stages breast cancer spreads locally in the breast and it spreads through the lymphatic vessels to the axillary nodes, also to the internal mammary nodes, and both of these funnel up to the base of the neck where the lymphatic vessels empty into the veins behind the head of the clavicle, so that you don't have very far to go from the primary breast lesion before the lymphatic drainage extends directly into the blood stream and becomes systemic. And of course there are a number of patients who have hematogenous spread of cancer cells during most of the course of their cancer history. Apparently, large numbers of those emboli do not "take", fortunately, so that the picture is not as black as it seems when you hear about the frequency of blood-borne metastases. The two avenues of spread that are amenable to surgical and x-ray attack are through the axillary nodes and the internal mammary nodes. The base of the neck is a

secondary drainage depot, and usually when you feel a node in the base of the neck that is metastatic, you already have systemic disease. On this basis, opposite conclusions have been reached. McWhirter in Edinburgh believes that if you have disease in the axilla there is no sense in doing an axillary dissection because you probably have disease in the internal mammary chain and neck as well. He advocates doing a simple excision of the tumor and then radiating this entire area with deep x-ray therapy to control the disease. On the other side, Wangenstein goes whole hog and not only cleans out the axilla and the internal mammary chain (he used to do the opposite internal mammary chain) but also the nodes in the base of the neck and the nodes about the hilum of the lung. I think that is a little too much.

Our own feeling on the matter is between these two extremes. We feel that one can remove the primary tumor and both of its primary lymph glands depots *en bloc*, and that is what we do. We apply the same attitude to the internal mammary chain as we do to the axillary chain. We don't make a biopsy of the axillary nodes when we do a radical, likewise we don't make a biopsy of the internal mammary nodes; we take them out where we suspect that we might have early disease in the nodes and where we feel the patient does not yet have systemic disease.

I am pretty convinced that McWhirter's technique is a step backward from the radical mastectomy procedure, and I think these figures are pretty conclusive.



Just look at the slide—these are the 5-year salvage figures for all primary cases seen in McWhirter's clinic in 1947. This excludes only patients who were treated before they came

to his clinic. And the second column is all the primary cases seen at the Memorial Hospital clinic who have had no previous therapy. These are comparable. They include inoperable, borderline, and operable material. His salvage rate in this group is 41 per cent. At a later date he reported 42 per cent. Our salvage rate with radical mastectomy is 49-plus per cent, about 7 per cent difference. The difference is actually somewhat greater since he had 100 per cent follow-up and we had 3 per cent lost to follow-up, all of whom were considered dead of disease. It is strange that in some of his papers he mentions the fact that radical mastectomy theoretically should be about 7 per cent better than simple, and it is. When you go further down and consider the primary operable cases, again you see about 8 per cent difference in favor of radical mastectomy.

I feel that McWhirter's technique is indicated only under very special circumstances, such as with a very poor risk patient, where you are justified in doing only a simple mastectomy and following with x-ray therapy. I think the only thing that McWhirter has proven is that if you have a carcinoma of the breast and you treat it with simple mastectomy and x-ray therapy you can salvage a fair number of patients. It is not better than a radical—it is not as good as a radical mastectomy.

We have been particularly interested in the internal mammary chain spread of breast cancer, and this is some of the statistical background. Handley in England surveyed 150 cases at the time of radical mastectomy, did biopsy on the internal mammary nodes and found that roughly one third of the patients had positive internal mammary nodes—that is 49 out of 150—and almost two thirds had positive axillary nodes. Internal mammary node metastasis is not a rare occurrence, it is quite frequent. About half the patients with axillary disease have internal mammary disease.

Dahl-Iversen in Copenhagen showed in 100 very early clinically operable breast cancers the following involvement in the node depots; 41 per cent in the axilla, 17 per cent in the internal mammary; 3 per cent in the supra-

clavicular nodes. I think that the important thing is that when the axilla is negative you very rarely find anything in the neck, whereas he had 8 patients out of 100 with positive internal mammary nodes only. This would again indicate that it is worth while treating the internal mammary area aggressively, by surgical excision, if possible.

This slide is some more of Dahl-Iversen's work showing a plotting of the position of the internal mammary nodes in about 43 odd cases. As you see, they extend roughly from about the costochondral junction to just under the edge of the sternum. The dotted area is the area we resect in doing an *en bloc* excision of this node depot together with radical mastectomy.

Here again is our anatomical basis for doing this procedure, showing the lymphatic vessels draining into the axillary nodes, also draining independently into the internal mammary nodes; the major drainage then extends up to the base of the neck from both these areas into the scalene nodes and also into the major blood vessels. Occasionally you get lymphatic drainage which extends from the internal mammary nodes downward directly into the liver.

I will go over these slides very briefly—for the technique of doing this, we maintain all the essential features of the radical mastectomy, wide skin excision, thin flaps, careful axillary dissection, and to that we add the *en bloc* excision of this portion of the chest wall, still in continuity with the overlying breast and pectoralis major muscle. This shows the flaps developed, the pectoralis major split between its clavicular and sternal heads, exposing the arch of the manubrium and the first rib. We then clear off the anterior surface of the sternum, peel off the rectus sheath up to the sixth rib and cut through the rectus muscle, exposing the sixth rib and then we excise this area of the chest wall. We first open the chest wall about 2 inches from the midline in the first interspace. Before going any further, we explore the base of the neck digitally, and in 4 patients out of 300 we found metastatic nodes either in the base of the neck or deep in the mediastinum, which were not palpable or visible by any other means. In these cases we

Primary Operable Breast Cancer COMBINED PROCEDURE - 5 YEAR SURVIVAL RATE				
55 Cases	Total Number	Alive free of disease	Alive with disease	5 Year Survival
All nodes clear	21	17	0	17
Only axilla invaded	12	8	1	9
Only int. mammary invaded	3	1 1 po death	0	1
Both axilla and int. mammary invaded	19	7	2	9
Entire group	55	33	3	36
40. % Pas. int. mammary		5yr. survival rate 65.4%		
56.4 % Pas. axilla		5yr. Clinically free of disease 60.0%		
Expected 5 yr. salvage rate (Clinically free of disease) for similar material treated by radical mastectomy and post op x-ray therapy 48.5%				

examined these nodes, found carcinoma, and closed the chest. We considered these patients inoperable, and did a palliative mastectomy on them, and then gave them extensive deep x-ray therapy to the mediastinum and base of the neck. But, if the base of the neck seems clear and the deep mediastinum looks all right, we go ahead, open the chest here, cut the soft parts from the under surface of the first rib and the arch of the manubrium, isolate the internal mammary vessels, tie them off as high as we can under the arch of the manubrium; do the same thing down here, go through the parietal pleura. Then with a sternal knife we split the sternum and develop a trapdoor in the chest, with the perforating vessels still in contact and in continuity with the internal mammary vessels. Then we run a finger beneath the pectoralis major muscle lateral to its insertion, which corresponds approximately to the parasternal area of the chest. With sharp, heavy shears we cut through the ribs and soft parts underneath here, and lay this trapdoor out on the chest wall, still in contact with the overlying breast and pectoral muscles and with all the perforating vessels extending into the internal mammary intact.

Another slide shows the defect in the chest wall with the trapdoor laid out, still covered with parietal pleura. Most of the nodes lie next to the sternum and out here. Next, we repair the defect in the chest wall with a fascia lata graft before working in the axilla.

We usually suture the mediastinal pleura to the edge of the sternum in order to close the

mediastinum from the chest cavity, and then we suture a fascia lata autogenous graft flush on the outer surface of the chest wall. In 50 cases we have used homografts of fascia lata which we obtained from the Navy Tissue Bank in Bethesda, and they are just as good, as far as we are concerned, as autogenous grafts for this purpose, and they are a lot more convenient. We always drain the chest with an underwater catheter for two days.

Then, after closing this area and approximating the edge of the fascia with a continuous catgut suture onto the chest wall, we complete the radical mastectomy by cutting off the pectoralis major from its attachment on the humerus, then the minor from the coracoid, and clean the axilla from above downward and lateralward. In order to facilitate primary closures of these wounds we frequently, in fact almost always, free the breast on the opposite side from its parasternal attachment to the sternum and underlying muscle. This mobilizes the medial flap and enables one to obtain primary closure.

In closing these cases we try to insure healing over the fascia graft by putting buried stay sutures over the sternum and through and through stay sutures in our flaps on the other side of the incision in order to remove tension from the suture line and also to hold the flaps against the chest wall and minimize fluid collection. We use two Penrose drains under the flaps and an underwater catheter in the chest. This diagram shows the relationship between the primary tumor and the lymph nodes in the internal mammary chain and the axilla, in a specimen we resected from a patient. You can do a better *en bloc* excision here with the internal mammary nodes because you sacrifice the accompanying vessels than you can in the axilla.

This slide shows a typical case with a 1 cm. lesion under the upper outer portion of the areola. You see there is some deformity of the nipple, but that is all that is visible. The axilla seemed clear but we decided to do an internal mammary section on the patient because in previous studies, going over 1000 operable cases in which we divided the breast in the varied quadrants and calculated the 5-year salvage rate, we found that the worst salvage

rates when axillary nodes were involved were the parasternal areas and the subareolas areas. Strangely enough, when the axilla is negative the subareolas area lesion has the best prognosis. But when axillae are involved it seems that you either get all nodes negative or both areas—internal mammary and axilla—involved together. With this clinical setup we elected to do this procedure.

This slide shows the operative specimen with a fairly good skin excision, a small hematoma in the specimen from the aspiration biopsy. And this is the undersurface of the specimen showing the portion of the chest wall which was resected. This is second, third, fourth, and fifth ribs, and sternum. The pathologist has already stripped off the soft parts and the internal mammary vessels but it gives a good idea of the extent of the chest wall excised.

And this is the patient post-op. Now this is a very nice patient as far as we are concerned, because she had only one positive node in the axilla and one positive node in the internal mammary chain. The axillary node was 8 mm., the internal mammary node only about 3 mm. in diameter. She had no x-ray therapy and is now 6 years free of disease. This is the sort of case we like to pick up and subject to this procedure.

Now I will just go over a few illustrations showing the operative field in several patients and give you our clinical findings and our results. This is the operative field just before closure, showing the fascia lata graft flush with the outer surface of the chest wall, sewed in very tautly, like a drum head. You can see the axillary vessels here, the long thoracic nerve preserved here, and fairly thin flaps here. This is the chest wall resection from this previous case showing very massive node involvement, between the internal mammary vessel and the sternum. One little node out here, and one here, but the big ones in here next to the sternum, really much greater involvement than we like to see.

And here is the same patient after this type closure. We used to put the fascia inside the chest wall, but now we put it flush on the outside and get less deformity. A lot of these patients appear like a conventional radical mastectomy.

We have done 290 cases using this type procedure, and we have our clinical data broken down for the first 270 cases. There are several points of interest here. Roughly half the patients had positive axillary nodes and 35 per cent had positive internal mammary nodes. Fifteen per cent of our cases in whom the axilla were clear showed internal mammary disease.

Now, we told you that the sectors A, C, and E, the parasternal and subareolar, did very poorly when the axillary nodes were involved. And sector A does very poorly whether the axilla is involved or not. You can see in sector A we have a higher involvement of internal mammary nodes than of axillary nodes—25 positive internal mammary nodes and 23 positive axillary nodes out of 63 cases. Now in sector E we didn't have any patients with only internal mammary involvement, but when the axilla was involved, 10 out of 17 cases had internal mammary involvement. Now I think that is probably one of the explanations as to why these subareolar lesions do so poorly when the axilla is involved. As you go out laterally your take of internal mammary nodes drops gradually and consistently, but not markedly. At first we used to concentrate on parasternal lesions and subareolar lesions. Then we did sectors B and D, and now we are doing lesions within 1 or 2 inches of the midline, but lateral to the midline, and we are still finding internal mammary disease. So, it is pretty hard to estimate just when to do this procedure rather than do a straight radical. If you have a good healthy individual with an inner quadrant lesion or subareolar lesion, this is a good procedure to do. If it is a little tiny lesion out in the tail of the breast with a clear axilla it is probably not necessary. The in-between group is difficult to determine.

This is a breakdown in which we divided the breast through the center from 12 to 6 o'clock and placed the lesions on either side, according to where the major portion of the lesion presented, and this is somewhat weighted, I believe, because most of our lateral lesions were close to the midline. Here you see, when the axillary nodes are positive, 60 per cent of the inner lesions had positive internal mammary nodes and 50 per cent of

the lateral lesions. Actually, if we included all of the lateral lesions it would probably drop to about 30 per cent or so. When the axilla was negative, here again there was a drop from medial to lateral. And here again these lateral lesions are close to the midline.

The internal mammary nodes between the internal mammary vessels and the sternum are more frequently involved than the lateral nodes. Not a great deal of difference.

This is encouraging in that it shows the highest involvement of the interspace levels is the second interspace, then the third, and then the first. We don't like to see it in the first interspace, it is just like finding a metastatic node in the apex of the axilla.

Most of the primary lesions are medial. Now, it is all very well to take nodes out of here, but can we salvage these patients when they have disease in the internal mammary nodes? You can salvage about a third of the patients who have positive internal mammary nodes at the 5-year mark.

Here are 22 patients with positive internal mammary nodes, 19 of them had axillary node involvement, as well, and in this latter group we have 8 free of disease at 5 years, and 2 living with disease, so we have 10 surviving 5 years. This is about 35 per cent free of disease and about 45 per cent surviving 5 years. In this group we did not have very early material—56 per cent axillary involvement, 40 per cent internal mammary involvement, and our 5 year salvage rate clinically free of disease is 60 per cent! excellent for this material. If we had projected these cases on our chart of 1000 cases which we treated with straight radical mastectomy and x-ray therapy—according to the location of the tumor in the breast and whether the axilla was involved or not—we would anticipate a 5-year salvage rate clinically free of disease of 49.5 per cent. We have increased the salvage by about 11 per cent. If we had lost 6 of these 8 patients with internal mammary involvement, we would have the same figure. These 6 patients probably represent the real increased salvage that we have obtained with this procedure.

In a breakdown of 20 patients with positive internal mammary nodes, (this is from an earlier group), we found that 10 of these pa-

tients had positive nodes in the apex of the axilla or in the first interspace, right on the edge of our dissection. All of these patients received post-operative x-ray therapy to the base of the neck, 2 of them are free of disease and 2 are living with disease. On the other hand, we had 10 patients who had positive internal mammary nodes where the first interspace was clear and the apex of the axilla was clear—we gave them no x-ray therapy and we have 50 per cent salvage (5-year salvage rate) free of disease in this group. It is the same story again. If we get these lesions early enough and do a more radical operation, we are going to salvage more patients. If we get them late, it doesn't make much difference how we treat them.

This is a breakdown showing the spread of disease in the first 7 patients with positive internal mammary nodes who are free of disease 5 years post-op. As you see only 2 of these

patients had x-ray therapy and one patient who was really loaded with disease locally also had surgical castration. She was only 32 years old. This woman had a positive node which we pulled out from under the first rib, and also had positive nodes at all levels in the axilla, but she is now free of disease. All the other patients had no x-ray therapy. You see the majority that were salvaged had involvement of the lower axilla, less involvement of the mid-axilla, and only one of them had apical axillary involvement. Likewise, in the internal mammary chain, when the second and third interspaces are involved, you get a good salvage rate, but when the first interspace is involved the patient is more likely to already have systemic spread.

Once again, our data emphasize the importance of getting these things as early as we can and treating them aggressively.

The Suppressive and Prophylactic Effects of Puromycin Against Intestinal Protozoa. Martin D. Young, M. D. and Joe E. Freed, M. D. (Columbia) Am. J. Trop. Med. and Hyg. 6:808 (Sept. 1957)

The suppressive and prophylactic action of puromycin was tested on patients of a mental hospital who were exposed to a high rate of infection with intestinal protozoa. In an exposed group of cases receiving 100 mg. of the drug daily for 10 days, about half the amebic infections were cured and most of the rest were suppressed. Weekly administration of as much as 500 mg. for five weeks effected few cures and failed to prevent new infections.

A group of patients on a heavily infected ward were then cleared of protozoa with one gram of puromycin

daily for four days, and about half of these were continued on a prophylactic regimen of 250 mg. thrice weekly for six weeks. The unprotected group began to acquire infections during the fourth week after cessation of treatment, while the rest remained uninfected throughout the six weeks of prophylaxis, although constantly exposed. Two weeks after prophylaxis was discontinued, this group also began to acquire infections.

All the patients receiving one gram daily had diarrhea on the fourth day and a few vomited, but these reactions disappeared on reducing or withdrawing the drug. The lower dosages did not produce side reactions.

CONTROLLED HEPATIC LOBECTOMY IN THE TREATMENT OF LIVER TUMORS

THEODORE R. MILLER, M. D.
New York, N. Y.

Doctor Eargle, members of the Medical College of South Carolina, I am going to speak to you today about the treatment of liver tumors. In this discussion we will include the metastatic lesions as well as primary liver tumors because of the relative rarity of the latter in this country. The differential diagnosis of hepatomegaly, either generalized or localized, lies among the inflammatory lesions, the benign tumors and the malignant tumors which may occur in this organ. We shall not comment on the inflammatory lesions other than to note that exploratory incision must be utilized as a diagnostic agent in many instances since the science of the clinical laboratory has not reached a point where the differential can be made with certainty in every instance. Complete studies of the liver function should be made in every case. The laboratory studies are often confusing because obstructive lesions will oftentimes produce hepatocellular disease which will be reflected in the laboratory results. X-ray examination with the demonstration of fluid levels and calcification in the mass may be suggestive either of amebic abscess or hydatid cyst of long duration. Some hemangiomas of the liver may show calcification as well. Calcification in hepatomegaly suggests benignity because of the length of time required for calcification to take place; however we have seen large metastatic renal tumors with calcification in the hepatic metastasis.

In general, the primary liver tumor has practically no symptoms in the early stage. Jaundice, pain, enlargement of the liver, and edema of the lower extremities are all evidences of an advanced situation. Most of the patients that we have seen in our clinic have either discovered the tumors themselves or come for examination because of some minor

digestive complaint and the examining physician found a large abdominal mass of which the patient was unaware. Occasionally the patient suffers acute abdominal pain and a large abdominal mass appears. The sudden abdominal pain is rather characteristic of some of these tumors. This is the result of hemorrhage into the tumor because of increase in abdominal tension in the act of bending or lifting.

Metastatic tumors of the liver are extremely common. Thirty to fifty per cent of all patients dying of cancer have liver metastasis. We have been studying this group in an attempt to increase the salvage rates but so far our experience has been very poor. The patient with simultaneous metastases is not salvageable by hepatic lobectomy; however the patients whose metastases may appear and are manifest clinically 6 to 8 years after the primary has been controlled, offer a group in which there is some chance for salvage.

A study of the distribution of liver tumors throughout the world reveals that they are rarest in Europe and most common in South Africa. In a hospital in Johannesburg 85 per cent of the admissions to the hospital for cancer are for primary hepatoma of the liver. Unfortunately most of these patients have such advanced cirrhosis with a hepatoma engrafted upon it that they cannot survive the surgery necessary for the removal. Primary hepatoma is common in South Africa, India, as well as the Chinese coast and Japan. This appears to be due to protein starvation in childhood with an early cirrhosis and consequently hepatoma engrafted upon it. Correction of the protein starvation in childhood offers an intriguing opportunity for the disappearance of this disease. There is a distinct difference in the frequency in the oriental races as compared to the occidental races. In the Orient liver cancer is responsible for 13 per cent of all cancers, whereas in the Occident the percentage is 0.14.

An address delivered on Founder's Day, Medical College of South Carolina, November 7, 1957.

In Charleston, in one series, 8 primary carcinomas of the liver were found in 2400 autopsies, so that the rate is 0.27. In spite of the rarity of the primary tumor the patient should be given the opportunity for surgical exploration.

Before discussing the surgical problem involved it would be interesting to discuss some of the anatomical points which we have been studying. The portal vein is formed by the superior mesenteric vein and the splenic vein. The length of the portal vein varies quite markedly in different individuals so that in the short portal vein the streams coming from the splenic and from the superior mesenteric may not mix. It is interesting to note that the coronary veins of the stomach empty into the splenic and therefore drain into the left lobe of the liver. This is also true of the inferior mesenteric vein which drains into the splenic vein. Lesions, however, of the small bowel and right colon drain into the superior mesenteric vein and therefore tend to go to the right lobe of the liver. The shorter the vein the more likely this will be true. In dissecting the portal triad the portal vein is quite well divided and rather regular in its configuration. The left portal vein is rather long and quite easily ligated, whereas the right portal vein almost immediately enters the hilum of the liver and is relatively short, making ligation somewhat difficult.

The arterial supply of the liver is much more irregular than the portal vein. It is very important that the arterial supply be carefully studied and demonstrated before either the right or left hepatic artery is ligated. The common hepatic artery divides, as a rule above the level of the cystic duct. However, the left hepatic artery and the right hepatic artery may come from the superior mesenteric or from the celiac axis directly. This has been carefully studied and documented in the past. The important point is that one must be sure that there is a hepatic artery supplying the remaining lobe of the liver.

The hepatic veins are fairly regular in draining into the vena cava. There are numerous smaller veins which must be ligated as the liver is lifted away from the vena cava from below upward. One must, of course, be sure

that all the hepatic veins are not ligated as this would produce a surgical Chiari's disease which is incompatible with life.

Lymphatic drainage has been well described and is apparently towards the liver hilum and down the portal triad to the retroduodenal nodes. There is also a group of nodes known as the juxtacardiac nodes just above the diaphragm which drain the lymphatics, which follow the hepatic veins and vena cava. The rapidity with which the retroduodenal nodes become involved in carcinoma of the gall-bladder is remarkable.

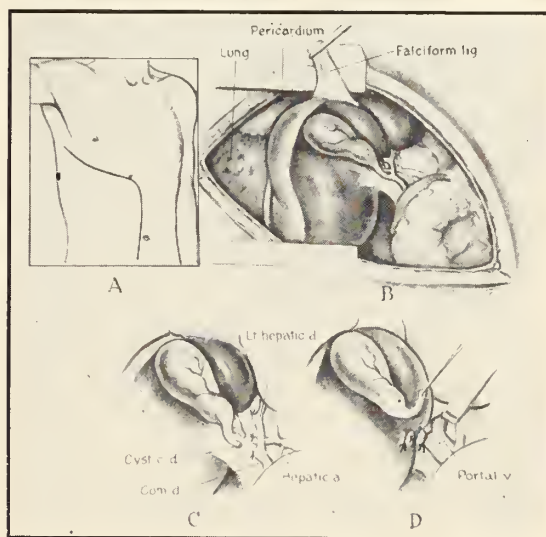


Figure 1

- A—Incision.
 B—Exposure of hilum of liver.
 C—Dissection of hilum showing ligation of cystic duct, right hepatic artery, right hepatic duct, and right branch of portal vein.
 D—Structures entering the left lobe are retracted to the left after careful preservation.*

The operation of right hepatic lobectomy is merely an adaptation of the above anatomical principles. The reason that liver tumors have been so neglected in the past has been the problem of control of hemorrhage. We usually use a subcostal incision with a T extending into the 9th intercostal space. The liver is lifted from the abdomen and rolled outward so that the biliary triad can be adequately visualized. The right hepatic duct and right hepatic arteries are ligated. The right portal vein is then identified and ligated. When these three structures have been controlled, about 70 per cent of the blood supply to the right

lobe is then obliterated. The hepatic veins are then carefully ligated as one lifts the liver away from the vena cava. The right lobe is then removed by breaking through the liver tissue at the septum using blunt and sharp dissection and mass ligatures to control the venous ooze. The raw surface is covered with the reflected falciform ligament to control the

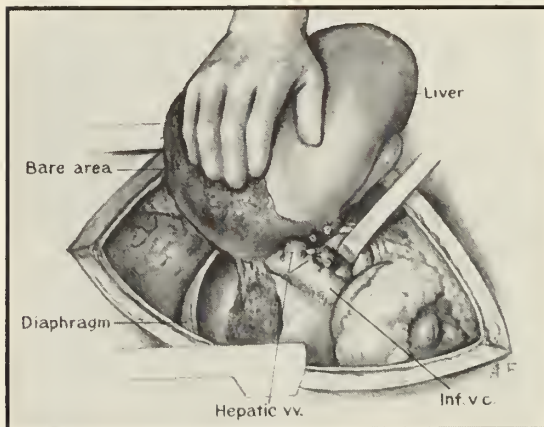


Figure 2

The right lobe of the liver is rotated to the left, exposing the vena cava and the hepatic veins, which are then ligated.^o

biliary leakage which takes place from the cut surface of the liver. We have used both hypotensive and hypothermia in conjunction with the anesthesia and feel that neither of these adds much to the safety of the patient. We ordinarily use pentothal and some relaxant as the anesthesia. Our series now consists of 14 total right hepatic lobectomies. Many of these have been for carcinoma of the gallbladder with right hepatic lobe metastases. Some are for metastatic lesions which have appeared 6 to 8 years after the control of the primary and a few for primary liver tumors.

The benign tumors of the liver that have been operated on have formed an interesting group. There are several large hemangiomas which are fairly rare. Many small hemangiomas are found in the course of routine abdominal explorations and require no therapy. Large hemangiomas can be shelled out relatively easily without much bleeding since there is a pseudo-capsule of condensed liver tissue about them. In the 16 right hepatic lobectomies which we have now completed there were only 2 operative deaths. The first

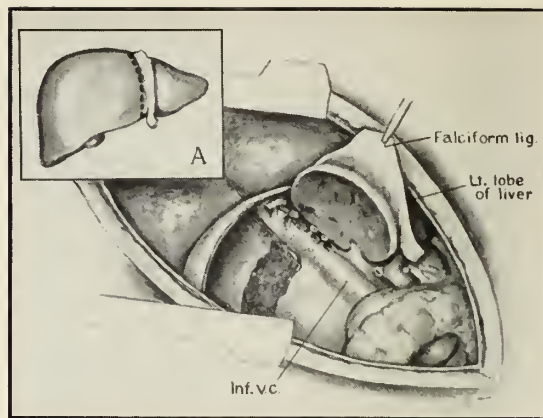


Figure 3

The right lobe has been removed.^o

was due to an error in ligation of the common hepatic artery and the second due to a disruption of a suture line in the duodenum which had been injured during dissection of the retroperitoneal nodes.

Resection of the left lobe of the liver is quite easily accomplished and has been recorded many times in the literature. We have proposed the addition of resection of the left lobe of the liver to extended total gastrectomy as a possible way of controlling metastases from the stomach, but so far have not done it in many cases.

During the routine study of the circulation of the liver we have discovered that the liver is really a multilobular organ much as the lung. It is quite possible to resect a middle section of the liver and preserve the left lobe

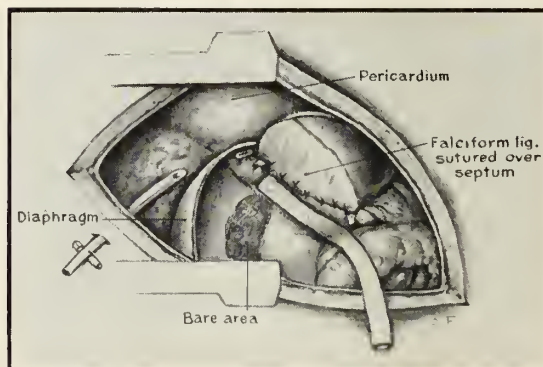


Figure 4

The raw surface of the liver has been covered with the falciform ligament. Drains are placed in the abdomen and chest before closure.^o

^o(From Pack and Baker, *Annals of Surg.*, Vol. 138, No. 2, Aug. 1953)

and the major portion of the right lobe. This is due to the fact that the hepatic veins are fairly regular in their configuration. We have studied this on the cadaver and are continuing to do so. We have also removed the middle lobe in one patient who is now living and well.

We have found that regeneration is rather rapid and that in the postoperative course practically all the patients develop a mild jaundice which we believe to be due to compression of the biliary duct by the sudden increase in the amount of portal circulation through the remaining lobe. Studies in the animal show that the regeneration is a cellular increase rather than an increase in the connective tissue. This can be demonstrated by

the count of the nuclei on sections.

In closing, the whole subject of liver tumor is an interesting one if a dismal one. The majority of tumors, of course, have rather bad prognosis but in spite of the fact that the average duration of the disease as judged by the interval between the onset of symptoms and death is comparatively brief, and the fact that primary carcinoma of the liver is one of the most rapidly fatal of all neoplasms, the patient should be given the benefit of surgical consultation and exploration in attempt to salvage the occasional patient with a resectable tumor.

139 East 36th Street
New York 16, N. Y.

NATIONAL LIBRARY WEEK

by Marchette Chute

The United States could not exist without the written word. Take it away and the country could not operate. Very little work could be carried on or knowledge transmitted, and the civilization we know would grind to a halt.

Nor can the United States exist without readers. Ours is a government of the many, not the few, and it is based on trust in its citizens. It trusts them to have formed the habit of finding out, and that means the habit of reading. We live in a complicated and difficult time, when we must be well informed if we are to survive, and as a democratic nation we depend on knowledge as we never have before.

Yet, as a nation, we have not formed the habit of reading. A Gallup poll of 1955 showed that 61% of the adults in America had not read any book except the Bible the previous year. Another survey showed that half the nation's adults live within a mile of a public library but only one fifth of them go inside. Reading has increased in recent years as measured in newspaper, magazine and book sales and in the use of public libraries, but the increase has not been as great as it has been in many other uses of leisure time.

Certainly the people of the United States have plenty of time for reading. We have cut the sixty-hour work week to forty hours. We have invented electrical appliances that replace a great deal of manual labor. We have lengthened the life span. The opportunity exists, and the leisure, but the American people have

not learned what can be done with it. . . .

Moreover, the habit of reading is not only vital to a democratic society but a source of enrichment to the individual himself. It is the people who read who have the most successful careers, for business and industry have never been able to find as many educated and intelligent men and women as they need. Moreover, any reader has in his hands one of the world's great sources of entertainment, an activity that can be practiced almost anywhere and at any age. A child can read under an apple tree, a traveller in an airplane, a housewife shelling peas, an old man bound to the immobility of a hospital bed; and each of them will be released into a world of delight that could never have existed for them otherwise.

The first emphasis of Library Week will be on the libraries of the United States, to make our fortunate citizens realize the value of this vast, free treasure that is spread out over the land, and to help them learn how to use it at full capacity. But from this beginning the activities of Library Week will reach out in many directions. It will focus attention on the vital importance of the school library, the college library, the home library.

It will underline the value of having books available in every room of the house — those easy, welcoming rooms in which every member of the family can read at his own pace and in his own way, and where even a small child can listen to a family hour of reading aloud and suddenly decide to explore for himself the magic that lies between the covers of a book.

INJURIES OF THE ABDOMEN

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In abdominal trauma a favorable outcome depends to a great extent upon the judgment of the surgeon as to whether to operate and, if so, when. The presence or absence of intra-abdominal injury does not necessarily manifest itself at the time by physical findings and laboratory tests. There is no definite symptom complex. The intra-abdominal injury may be masked by associated injuries, shock, concussion, and alcoholism. There is general agreement that active bleeding and rupture of a hollow viscus demand urgent operation, but in the early stages their presence cannot always be determined with any degree of certainty. One must be constantly aware that damage may have been incurred out of proportion to the severity of the trauma. One cannot wait for diagnostic signs. In some cases, the decision to operate must be made upon a well-founded suspicion, weighing the risk of operating under unfavorable conditions, or even unnecessarily, against the dangers of delay. In case of associated injuries such as cerebral or thoracic damage, or fracture of the spine or long bones priority of treatment must be given careful consideration.

Supportive measures as indicated should be instituted at once. These include fluids and blood by vein, oxygen by nasal catheter, gastric suction, tracheotomy, and drugs. In case of penetrating wounds, operation should be performed as soon as the condition of the patient permits; in the presence of active bleeding it should be performed urgently. At operation the wound of penetration should be eared for adequately, but it need not be incorporated in the incision made for exploration. In case of gunshot, the exploration need be more extensive than in a stab wound. Associated intra-thoracic injuries should always be kept in mind.

Blunt trauma presents the more serious

From the Roper Hospital and the Medical College of South Carolina, Charleston, South Carolina. Presented before the Committee on Trauma of the American College of Surgeons; February 7, 1958. Charleston, South Carolina.

problem as to the question of operation. The injury incurred need not be in proportion to the severity of the trauma. Minor trauma may result in serious injury, and, on the other hand, in severe injury, the abdominal wall may be undisturbed showing not even a bruise.¹ The common injuries are laceration of a solid viscus and perforation of a hollow one. There have been reported such bizarre conditions as cholecystectomy, and avulsion of the spleen with control of hemorrhage by thrombosis of the vessels at its pedicle.² Certain types of injury do not manifest themselves early by physical signs or laboratory tests. Such are subcapsular hemorrhage in the spleen, retroperitoneal hemorrhage, and the escape of non-irritating contents from a hollow viscus, the last in marked contrast to a perforated peptic ulcer. The findings from a four quadrant abdominal tap,³ repeated at intervals, if necessary, are important if positive;⁴ likewise x-ray evidence of free gas in the peritoneal cavity. An increase in the white blood count is of little diagnostic significance, while a falling hemoglobin and volume of packed cells are indicative of continued bleeding. The presence or absence of abdominal tenderness and rigidity may be helpful or misleading depending to some extent upon associated injuries. The decision as to operation may have to be based upon the general impression of the case, taking into consideration the severity of the trauma which, at times, may be best indicated by the associated injuries, in which case decision must be made as to concomitant approach or priority of treatment.

General anesthesia should be used when conditions permit. Spinal anesthesia is contraindicated in the presence of shock, and especially in case of a possible perforation of the bowel, as the increased peristalsis would cause an emptying of its contents into the peritoneal cavity. A vertical mid-line incision is

¹ I have had some doubt about the safety of this procedure, but it is looked upon favorably by other members of the staff.

generally preferable as it can be extended as indicated downward or upward, and into the thorax. The peritoneal cavity is first emptied of blood so that a satisfactory exploration can be made. Injuries should be noted as they are discovered and care be taken not to overlook multiple injuries, especially perforations.

The spleen is the solid viscus most commonly injured. It may suffer lacerations of various degrees or even be torn from its pedicle. Bleeding may be free and severe from the start, or it may be delayed or reduced as a result of shock. A subcapsular hemorrhage may not manifest itself for hours, or it may even become organized and give rise to late complications. In case of injury the spleen should be removed; attempts to preserve it by suturing lacerations have long been abandoned as dangerous.

Lacerations of the liver initially bleed freely and when extensive are probably the most common cause of early death. The loss of blood is generally apparent, and operation is urgently indicated. Loose fragments and badly damaged tissue should be excised. The larger vessels should be controlled with large caliber transfexion sutures. Large Gelfoam or Oxycel packs are often of value. Adequate drainage must be provided to take care of the leakage of bile. Secondary hemorrhage is not uncommon. Late sequelae are liver abscesses, hemobilia, and cholangitis.

The pancreas is subject to injury due to its fixed position over the spine. Hemorrhage should be controlled and adequate drainage provided. Late sequelae such as cysts or pancreatitis are not uncommon.

The stomach is subject to perforating wounds and lacerations. These can generally be satisfactorily repaired by suturing. The posterior wall of the stomach must be examined and a search made for wounds in the liver and diaphragm. Perforation of the posterior wall of the duodenum is a serious injury which is not uncommonly overlooked. Gas and liquid contents pass into the retroperitoneal space. At times, it can be detected by x-ray examination before operation. At operation, the retroperitoneal tissues must be

examined for emphysema and hemorrhage with this particular injury in mind.

The small intestine is subject to perforation, laceration, bursting, and contusion. Perforation does not always manifest itself early. An eversion of the mucosa may temporarily occlude the opening. Associated ileus may diminish the escape of its contents. In some instances the intestinal contents may be relatively non-irritating to the peritoneum in which case the condition would become manifest only upon the development of peritonitis. Delayed perforation occurs when bowel necrosis results from a tear or contusion of the mesentery. Injury to the small intestine must be treated promptly by suture or resection with re-establishment of continuity. The peritoneal cavity is not drained.

Injury to the colon presents a more serious problem. Perforations of the right colon generally require only suturing due to the liquid nature of its contents. On the left, the use of proximal colostomy or exteriorization would depend upon such factors as the extent of damage to the bowel, the general condition of the patient, and whether the bowel is empty or full. If the bowel is so badly damaged that there is question about a satisfactory healing, exteriorization is indicated if easily accomplished, or some other type of colostomy should be performed. Extra-peritoneal injury to the rectum is potentially very serious. Proximal colostomy and perineal drainage are generally advisable.

In conclusion, it can be said that in many instances intra-abdominal injury due to trauma does not manifest itself early and that its presence or absence can not be diagnosed with any degree of certainty. Where there is reasonable likelihood that such injury may exist and the general condition of the patient permits, it is safer to operate for the establishment of diagnosis as well as for treatment.

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MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Hypokalemia (and metabolic alkalosis)

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Department of Medicine

Case Record—An adolescent girl with a past record of excellent health and outstanding academic achievement was brought to the attention of physicians because of weight loss and personality changes. Most prominent feature of her history was a growing obsession to restrict her daily intake of food and fluids for the avowed purpose of becoming slender. Within a few months she had become strangely sullen, withdrawn, and undernourished to an alarming degree. When forced to eat she would retaliate by self-induced vomiting. A diagnosis of acute schizophrenia was ultimately established, and such physical and electrolyte abnormalities as were noted in this patient at several examinations were deemed to be secondary to that mental disorder.

On one of several admissions to the hospital for psychiatric care she was found to have an advanced degree of malnutrition with a metabolic alkalosis. Her serum potassium was 2.4 milli-equivalents per liter (normal range 3.5 - 5) with a low level of blood chlorides (53 m. Eq.), a high CO₂ combining power, and a mild azotemia at the time the electrocardiogram on the left was made. That on the right was recorded a week later following intravenous and tube feedings.

Electrocardiograms—The tracing before treatment is characterized by the presence of conspicuous U waves in most leads, becoming of huge proportions and dwarfing the immediately preceding T waves in V-3, V-4 and lead II. T waves are of low amplitude throughout but can be seen distinctly in V-2 and aV1 where the Q-T interval measures 0.33 sec. This is identical to the Q-T interval after treatment and is within the normal range for these heart rates in females.

Another feature was that of numerous ventricular ectopic beats with runs of bigeminal and quadrigeminal rhythm which were seen in long strips of tracing recorded on admission. Lead III shows one such extrasystole. The P waves also undergo some change which is evident in leads II and III, they being 1 mm. higher and somewhat peaked before treatment. But no change occurs in the P-R interval of 0.16 sec.

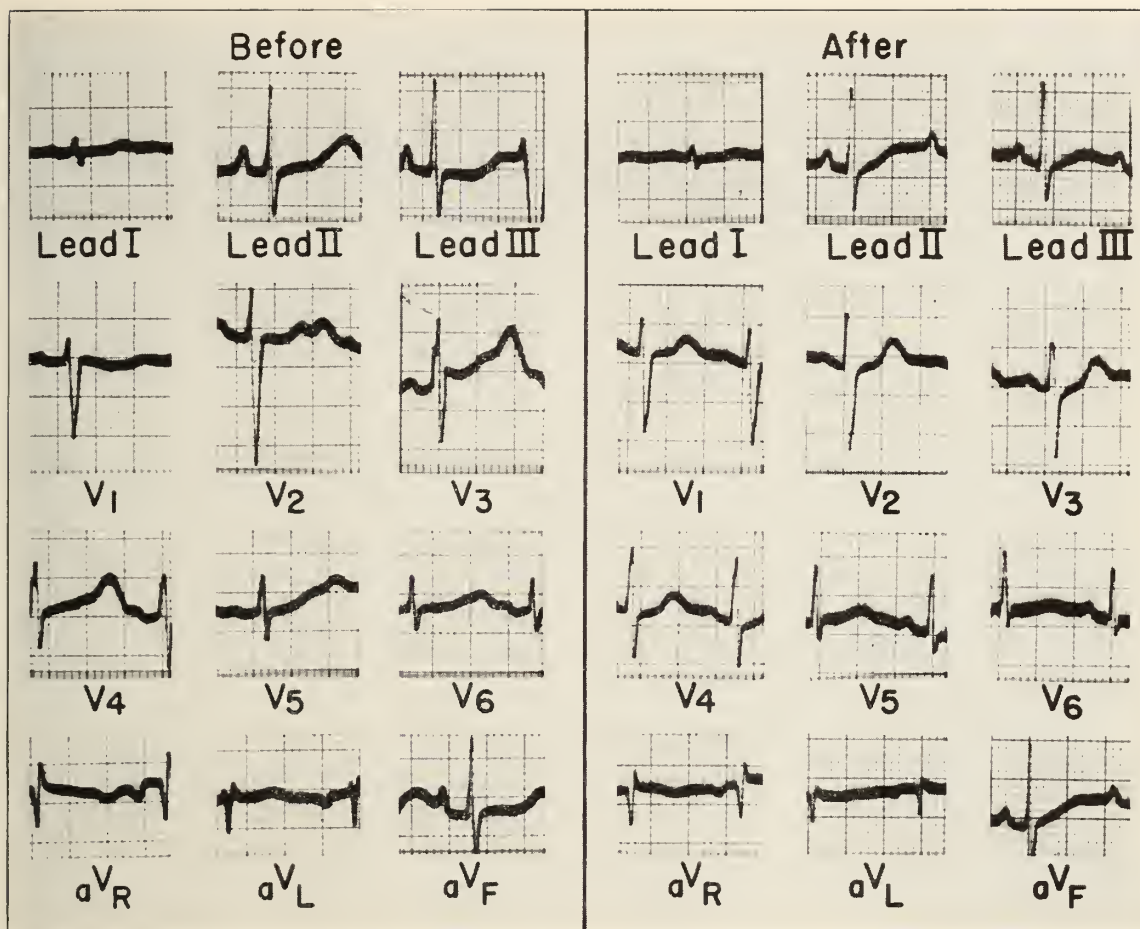
The tracing on the right is normal although the T

waves are still of rather low amplitude in several leads.

Discussion—It has been known for many decades that the chemical environment of the muscle cell and, more specifically, the differences in concentration of certain electrolytes on the two sides of the cell membrane have much to do with its electrical activity. Only in recent years, however, has the electrocardiogram enjoyed much clinical usefulness as an indicator of electrolyte abnormalities. In this application it has several obvious advantages, most notable of which are the facility with which the electrocardiogram is recorded and the immediate availability of the results. Hence it is of particular value in emergencies and as a guide for therapy in certain renal and metabolic disorders. But much remains to be learned of the interrelationship of chemical and electrical changes, and of the interpretation of these changes in the electrocardiogram. Causes other than electrolyte imbalance can alter the complexes in ways which are as yet indistinguishable from some of those ascribed to potassium and calcium. The ECG serves as an indicator rather than a measure of derangement of body chemistry.

Formerly it was believed that the Q-T interval, which is measured from the beginning of the QRS to the end of the T wave, was prolonged in hypokalemia, or potassium deficit. But recent studies have demonstrated that this is more apparent than real, that what actually does occur with a low potassium is accentuation of the U wave (normally an inconspicuous "after potential" immediately following the T) simulating prolongation of the Q-T interval. Where the T and U waves are sufficiently well demarcated it can be shown that hypokalemia produces no essential deviation from normal in the Q-T interval which is determined largely by the heart rate, age and sex of the patient. This illusion of a prolonged Q-T is enhanced by a second characteristic of potassium deficiency, namely a general lowering of amplitude of the T waves so that the U wave may be easily mistaken for the T. Both of these characteristic changes, and a third, the ectopic arrhythmia, are evident in a comparison of this patient's tracings before and after treatment.

Other ECG changes attributed to hypokalemia are less specific. A depression of S-T segments is said to occur when potassium depletion is more severe, as with a serum level of 1.5 milli-equivalents or so. Occasionally the P-R interval may be lengthened. The high peaked P waves which are seen in this patient's tracing prior to treatment are not ordinarily considered part of the hypokalemia pattern but conceivably



might be expected since the opposite condition, a high level of potassium, decreases the amplitude of P waves while increasing that of the T wave complexes.

To date little is known of the origin and significance of U waves in the electrocardiogram. One theory, that they denote a phase of supernormal excitability of the muscle following repolarization, has been cited as an explanation for the frequently observed appearance of ectopic beats at this point in the cardiac cycle and the perpetuation of coupling in a bigeminal rhythm. (Incidentally, the ventricular ectopic beat seen here in lead III begins some 0.06 sec. after the time of maximum U wave voltage). As a rule U waves are displayed best in the precordial leads where they normally are of the same direction as their associated T waves and often appear to merge with them. Rarely U waves may exceed even the R in height though in most electrocardiograms they are inconspicuous and go unnoticed. Whatever else they may signify, they have useful clinical significance in hypokalemia in which accentuation of U waves is one of the most constant findings and in which administration of potassium is followed by a diminution in their amplitude and a suppression of ectopic arrhythmias.

It is a recognized fact that electrocardiographic signs of an electrolyte imbalance may not parallel exactly the levels of that electrolyte in the blood. Several reasons for this have been suggested, among them the fact that more than a single electrolyte are commonly involved in metabolic derangement, and abnormality of one may exaggerate or repress the effects of another. Moreover, the effects on the ECG may stem principally from the intracellular rather than the extracellular concentration of an element. So far as the cell is concerned, we are "on the outside looking in" with our determinations of potassium level in the serum. Severe deficits of intracellular potassium can follow loss by prolonged vomiting or diarrhea, deficits which may have to be satisfied before an appreciable rise in the serum level of K can be sustained.

Hypokalemia is seen in "pure culture" in familial periodic paralysis where levels of potassium in the serum have been shown to fall precipitously during the attacks of muscular weakness. Other causes, aside from a variety of gastrointestinal disorders, are Cushing's disease, diabetic coma (recovery phase), and excessive administration of steroids.

In this case repeated vomiting resulted in loss of

large amounts of acid and potassium-containing secretions from the upper gastrointestinal tract and, consequently, hypochloremic alkalosis and dehydration. Doubtless contributing to the dehydration—and the “prerenal” azotemia—was the patient’s self-deprivation of food and fluids. A recheck of her blood chemistries two weeks after the first electrocardiogram revealed normal values for electrolytes.

Acknowledgement: The author is indebted to Dr. John H. Felts of the Bowman Gray School of Medicine for metabolic data on this patient and loan of the electrocardiograms.

DEATH OF FETUS IN UTERO

A Case Report

LAWRENCE L. HESTER, JR., M. D. AND
LOUIE NESMITH, M. D.

Department of Obstetrics and Gynecology

A 34 year old colored female, gravida 10, para 7, abortions 2, whose last menstrual period was November 19, 1956 and estimated date of confinement August 26, 1957 was seen first on April 6, 1957. She gave a family history of hypertensive vascular disease, but a negative history for diabetes, syphilis, tuberculosis, and rheumatic fever. She had pre-eclampsia with her third pregnancy in 1947, but no evidence of toxemia with her other pregnancies.

Physical examination on April 6, 1957 was negative. Her weight was 179 pounds, and her blood pressure 130/68. On abdominal examination the fundus of the uterus extended 24 cm. above the symphysis pubis. Fetal heart tones were present at 136 per minute. Pelvic examination showed the cervix to be blue on speculum examination and ulcerated slightly at the external cervical os. The vaginal and rectovaginal examination confirmed the uterine enlargement. The hemoglobin was 10.5 grams, Wasserman and Kline tests were negative, Rh factor test was positive, urinalysis negative, and chest roentgenogram negative.

She was advised to return to the clinic for monthly visits, but missed May, 1957. On June 3, 1957 her weight was 177 pounds, blood pressure 110/60 and her abdomen was enlarged proportionally to her period of gestation with fetal heart tones present. On June 7, 1957, prenatal examination was essentially the same. On June 24, 1957 she returned to out-patient clinic stating that fetal movement had ceased 3 days previously, and she complained of general malaise. Her weight was 178 pounds, temperature 98.6 degrees centigrade, and blood pressure 110/70. Abdominal examination revealed the uterus to be enlarged to approximately 32 weeks gestation. The uterus was soft and the usual resistance offered to the palpating hand by a living fetus was not present. Fetal heart tones could not be heard. AP and lateral roentgenograms of the abdomen showed signs of intrauterine pregnancy of approximately 32 weeks. There were no radiological signs of intrauterine fetal death. On July

5, 1957 the uterus extended 21 cm. above the symphysis pubis and no fetal heart tones could be heard. On July 12, 1957 repeat film of the abdomen showed a fetus of approximately 28 weeks gestation and there was marked overlapping of the cranial bones. The radiological impression was “Positive Spaulding’s sign indicating intrauterine fetal death.” Because of the association of hypofibrinogenemia with intrauterine fetal death,¹⁻⁷ bleeding time, clotting time, and clot retraction tests were done. The bleeding time was 4 minutes and 5 seconds, clotting time 6 minutes and 30 seconds, and the clot retraction was normal.

The patient was informed of the diagnosis of intrauterine fetal death, and it was explained to her that it was best to follow her at weekly intervals and not to attempt an induction of labor. She seemed to accept this; however, the following week she and her husband returned, both upset and requesting that something be done to terminate the pregnancy. The problem was explained again and they seemed to accept the situation.

She was followed at weekly intervals until August 22, 1957. The bleeding time, clotting time, clot retraction, blood pressure, urinalysis were all normal on each visit. The incidence of hypofibrinogenemia increases rather markedly after 5 weeks of intrauterine fetal death (2) and since she had been followed for 8 weeks with no evidence of fibrinogen depletion, it was thought that an attempted induction of labor should be carried out by the use of intravenous pitocin.

She was admitted to Roper Hospital on August 22, 1957. Sterile pelvic examination after admission revealed a soft, non-effaced cervix that admitted one finger. The presenting part was unengaged. She was given 5 minims of pitocin in 500 ml. of dextrose in distilled water by slow intravenous drip at 12 drops per minute. This was repeated in 8 hours. The pitocin infusion initiated only mild uterine contractions that were fleeting in nature. Following the pitocin, sterile pelvic examination revealed no change in the cervix. There was no abnormality in the clotting mechanism, or clot retraction before or after the intravenous pitocin. Following the failure of the medical induction, the patient was discharged to be followed in the out-patient clinic. It was felt that although this patient was a grand multipara, the need for delivery outweighed this relative contraindication to intravenous pitocin. It was not thought, however, that the indications for delivery were great enough for surgical intervention such as rupture of the membranes or hysterotomy.

On August 30, 1957 she was admitted to Roper Hospital in active labor with the cervix 4 cm. dilated, 60 per cent effaced, and the presenting part dipping into the pelvis. She delivered a 3 lb. 3 oz. badly macerated infant after a labor of 7 hours, and with an estimated blood loss of 200 ml. Her clotting mechanism was normal before and after delivery. Her postpartum course was uneventful and she was discharged 24 hours after delivery.

Discussion: Everyone who practices obstetrics has, at some time, a patient with death of fetus in utero. This difficult problem is made more so because the treatment is to await the onset of spontaneous labor. If the patient is emotionally stable, then she is told of her diagnosis. If it is felt that she cannot tolerate this information, then the husband or some other member of the family is informed.

The problem arises as to how long one should wait for a spontaneous delivery without attempting medical induction. It has been shown that hypofibrinogenemia occurs much more frequently if the fetus is 16 weeks or older before death, and if the fetus has been dead for more than 5 weeks.² Recently there have been reports of hypofibrinogenemia in early missed abortions.¹ Eastman³ states that malaise from absorption of necrotic products of the dead fetus is a non-existent problem. He states that these symptoms always appear after the patient has been told of the intrauterine fetal death, indicating a psychogenic origin.

Our policy is to follow these patients with tests of bleeding time, clotting time, and clot retraction at weekly intervals in the out-patient clinic or office for 8 weeks. If the clotting mechanism is normal for this period of time, nothing is done. After 8 weeks, the patient is admitted to the hospital and intravenous pitocin administered in an attempt to initiate labor. Intravenous pitocin may be repeated for as many as

six courses if desired.⁴ After 8 weeks calcification of the fetus may occur with uterine perforation and possible formation of a fistula.⁶ This possibility is not great enough to risk infection by surgical intervention. If a fibrinogen deficiency occurs while one is following the patient, then delivery is mandatory by the easiest and safest method available after the fibrinogen defect is corrected. Estrogen has not been used to prime the uterus before pitocin drip, and we have had no experience with Relaxin or related compounds.

Summary: A case of death of fetus in utero is presented. The conservative treatment, watchful waiting, is stressed.

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Antibiotics in proctology. Leon Banov, Jr., M. D. (*Antibiotics Annual*, 1956-57, 180.

This is a summarizing report of investigations of antibiotics in proctology under the auspices of the Department of Surgery of the Medical College of South Carolina.

Because infection appears to have an important role in the pathogenesis of anorectal inflammatory lesions, the use of antibiotics has a rational and logical basis. The broad-spectrum antibiotics have a definite place in the management of proctologic lesions because they combat the infection, relieve the pain of inflammatory edema, and reduce morbidity.

Although the use of antibiotics is only palliative, nevertheless, palliation is often necessary in the management of the common nonspecific inflammatory lesions of the anorectum, i. e., hemorrhoidal disease, anal fissure, papillitis, cryptitis.

Since there is an inflammatory component in most, if not all, rectal strictures of lymphogranuloma venereum, the use of the broad-spectrum antibiotics is indicated.

Neither erythromycin, 400 mg. every six hours, nor tetracycline, 250 mg. every six hours, orally administered for three to seven days, significantly promoted postoperative wound healing of the anorectum.

Leon Banov, Jr.

MODERN MEDICINE ON TRIAL

PRESIDENTIAL ADDRESS

D. LESESNE SMITH, M. D.

Spartanburg, S. C.

During the past few years I have become increasingly conscious of the many threats to the very existence of modern medicine.

First, I would like to take a brief look at our scientific progress over the past few years; second, to see what the patient is receiving from the profession, with a few suggestions for improvement, and last, to review the forces which have our profession on trial.

In the last generation while the world has advanced from the horse and buggy to space satellites, there has been much progress in medicine and surgery. One of the greatest changes has been in the new concept of tissues. Gentleness in handling tissue has changed the operative and post-operative course of the patient. The six minute appendectomy has gone. Another great change has been improved anesthesia, enabling the surgeon to enter any cavity of the body. Antibiotics virtually control almost all infections. The use of replacement fluids, blood and plasma, with the laboratory controls, has advanced the safety of surgery. Recent surgical techniques have entered new fields allowing the replacement of arteries, skin and even kidneys. Tissue cultures of every organ promise vast new possibilities. The vista of the future opens dazzling possibilities of chemotherapy or antiviral therapy for cancer. The mortality rate is the lowest in our history, and life expectancy has been increased by nineteen years.

We thus see that during the last 30 years the medical world has seen the greatest advancement in the diagnosis and treatment of disease than any period in our history. In order for the patient to receive the benefit of our vastly increased knowledge, we must earn his respect and affection by living lives of integrity and generosity, not only medically. We must contribute to the religious and civic life of our communities—"To whom much is given, much is required."

We must have services available to the patient in his times of need. When more than the average attention is required, hospitals with more comprehensive facilities ought to be available. These services should be obtainable in a way that will be financially feasible for the individual. Pre-paid attention on a voluntary basis is the answer of the profession. Let us remember that no matter what system is used, it can also be abused. Too often expensive hospitalization could have been avoided by a good history and physical examination. A knowledge of the patient's family with a desire on the part of the physician to treat and cure him without unnecessary expense is indispensable.

Every thoughtful doctor should consider whether or not it is to the patient's advantage to have him hospitalized. Have you not seen the incurable, the patient in his last illness, where life has nothing more to offer, being kept alive without hope month after month by artificial means and supportive measure? Yes, if medicine is to meet its trial we must deliver our services in a conscientious thoughtful way.

It behooves the doctor to study the religious fibre of his patient; to learn something of his beliefs and outlook, for when death is inevitable, the doctor can help the patient and the family as an individual, rather than as a scientist.

With a more enlightened laity and the fact that medicine is no longer a mystery to the general public, the doctor must become an educator if he wants to retain the respect due him. Doctors have a responsibility to educate their patients about diseases that are inherited. What is more hopeless than propagating a large family of hemophiliacs or progressive muscular dystrophies and other known familial diseases?

We of the medical profession received our education not only as a result of our own efforts but through the foresight and sacrifice

of others. Many of us received our training at state institutions, others at independently supported medical schools, but in either case, our predecessors created the knowledge which was so graciously, though laboriously, bestowed on us. I am sure that the majority of physicians feel obligated to pass their knowledge on to their fellow doctors and to their patients as best they can.

The trained mind of a physician and his character are his only capital assets. He must use these to the best advantage of his fellowmen, not only as a doctor but as a citizen. He has a responsibility to see that his medical community, his hospital and his health department, as well as the auxiliary medical services, are conducted in the way most beneficial to the public.

With the shortage of registered nurses it is now necessary to train more practical nurses. Home care for the chronically sick, the development of chronic disease hospitals and boarding homes for the infirm and aged, are our most urgent needs. Our hospitals with specialized services need relief from the overwhelming load of the chronically ill they now have to take care of.

Our freedom to practice medicine as we are now doing is actually on trial because of the socialistic tendencies of the American people. Everyone wants something for nothing. Pressures are brought on our law makers to furnish more medical services without cost to the individual. Labor unions are offering more in

order to control their members.

Effort must be made by the physician to ward off the assault of political forces. Our profession put up a noble and victorious fight against Oscar Ewing's direct attack and we won the first round. Since that time, flank attacks are constantly being made.

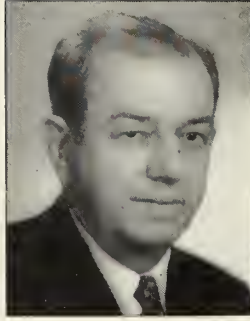
Thirty-four million people are now eligible for tax paid medical care. The numbers and categories grow with each legislative session. The Forand Bill is now the most menacing threat on the horizon. If this is successful in Congress, all of the millions of people receiving social security will soon be eligible for both free hospitalization and medical attention. The initiative and freedom of the American physician can pass into the hands of the politician.

Modern medicine has resisted successfully the attempts to place it under social security, the only professional group in America that has held out against it, for the majority of doctors realize that freedom in practice is their greatest incentive.

The substitution of state medicine for private practice in other countries has been a failure, for it has resulted in tyranny. The failure of socialism as an efficient economic system is clear. The doctors of America have fought gallantly against such a system. The pendulum the world over is beginning to swing back toward free enterprise but we must remember the words of Daniel Webster, "Liberty, private property, prosperity; one and inseparable, now and forever."

The continuance of the practice of indiscriminate T and A is indeed an enigma. We live in a medical era which considers itself "scientific." We like to think that we have rid ourselves of the mumbo jumbo and mystical nostrums of the past and we adopt new procedures only after rigorous testing. Yet T and A, whose uselessness, in the overwhelming majority of instances, has been repeatedly and convincingly demonstrated, retains its popularity with the laity and the medical profession. Would we, on the basis of such tenuous evidence as is available in favor of T and A, adopt a new drug which may be lethal for some 300 persons a year?

H. Bakwin—*Jour. Ped.* 52:359



PRESIDENT'S PAGE

I wish to extend greetings to you, the members of the South Carolina Medical Association, in this communication, my first for the President's page.

It is a rich privilege for one to be elevated to the presidency of his State Medical Association. I realize the honor you have bestowed upon me and with this in mind will try to conduct the affairs of the office in a dignified and efficient manner that will merit your confidence. This can only be accomplished with the full and whole hearted cooperation of every member in helping me to uphold our "Principles of Medical Ethics."

These principles are not laws but merely standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions and with the public. The main objective of our great profession is to render service to humanity with full respect for the dignity of man. All of us should merit the confidence of patients entrusted to our care, rendering to each a full measure of service and devotion.

With your support I will, as President of the South Carolina Medical Association, endeavor to conduct its affairs in a manner that will preserve this principal objective.

R. L. Crawford, M. D.

Editorials

MEDICINE'S FOURTH ESTATE

Every active physician recognizes the constantly growing importance of his county, state and national medical societies—the three great “estates” of organized medicine in America.

In the past few decades, medical practice has become ever more complex. Doctors today must deal not only with more than a score of fellow medical specialists, but with several score of “paramedical” technicians, many of whom are finding it difficult to adjust themselves to a “table of organization” in which the Doctor of Medicine must, by training and responsibility, be the captain of the team.

Then, too, in the areas of hospital-physician relations, of public health, of medical care prepayment, and of social security, organized medicine is required to think in new terms and to act with decision, if it is to retain the leadership which the people expect of their physicians. The demands of our time call for medical statesmanship of the highest order.

And now, medicine has added a “fourth estate”, The World Medical Association, which, though it was founded only a little more than ten years ago, has already earned for itself world-wide recognition as “the international voice of organized medicine”.

Our American Medical Association is one of the 53 national medical associations which comprise the membership of The World Medical Association. Within the United States, some 5,500 leading American physicians have formed a supporting committee, known as the United States Committee of The World Medical Association. President of the U. S. Committee is Dr. Austin Smith, Editor of the Journal A. M. A., and its Secretary-Treasurer is Dr. Louis H. Bauer, who has also served as Secretary General of The World Medical Association since its founding in 1947.

The purposes of the U. S. Committee are those of W. M. A. itself: to work for the highest standards of medical care in all parts of

the world; to defend and preserve the freedoms that are essential to good medical practice; to provide a forum for the solution of problems common to physicians the world over; and to promote world peace.

You have an opportunity to play your part in this vital cause by becoming a member of the U. S. Committee of W. M. A. The A. M. A. House of Delegates has urged that every member of A. M. A. join the U. S. Committee. Annual dues are \$10.00, and the Committee's headquarters are at 10 Columbus Circle, New York 19, New York.

Our local chairman is Dr. Joseph P. Cain of Mullins.

A PLEA FOR THE RHEUMATIC

With the exception of the acute upper respiratory infection, there is no greater cause of loss of time from work than the rheumatic diseases. These become an increasing problem as the number of people in the older age groups increase. It is true that the rheumatic seldom dies of his disease and his disease is not a dramatic one. However, I believe that these people are entitled to all the help that the medical profession can give them.

In studies throughout the United States, it has been found that a large percentage of these are not under treatment, largely because of the indifference of the medical profession. This also has driven a large number to pseudo-medical men.

In the next year, the Arthritis and Rheumatism Foundation will begin its work in South Carolina. And we would like to increase the interest in the American Rheumatism Association. We earnestly solicit your interest, help, and encouragement.

E. Walter Masters, M. D.

THE NO-FREE-CHOICE-OF-PHYSICIAN CONTRACT

The writer has recently had the pleasure of reading a paper with the above title written by Dr. Harry Mantz who is a specialist in

internal medicine practicing in Alton, Illinois, and also a member of the Grievance Committee of the Illinois State Medical Society for the past several years. Dr. Mantz' paper is abstracted and condensed herewith with his permission.

Dr. Mantz states that organized medicine faces a deadly threat from an attack by certain large organizations which are setting up their own health service plans for their employees or members, examples of which are the United Mine Workers Fund, the Permanente Foundation of California, and the so-called H. I. P. in New York. In addition, the United Automobile Workers under Walter Reuther is contemplating a similar contract for the UAW Health Fund. In essence, these contracts do not allow patients a free choice of physician, and there is no fee for service because the physicians are usually on a salary.

Usually there are three stages leading to the full-blown condition described. As exemplified in Illinois, the United Mine Workers Fund approximately 10 years ago seemed most anxious to cooperate with organized medicine. As the Fund's services became better organized, the Fund began a period of "no cooperation" with the Illinois State Medical Society. It increasingly restricted its panels of doctors, and the numbers of hospitals to which it would send patients, and it refused to bargain with the Illinois State Medical Society on the basis of the guides which were approved in the House of Delegates in May of 1957. It claimed that it could no longer allow free choice of physicians because of abuses of the Fund by private physicians. Dr. Mantz states that he has been on the Grievance Committee of the Illinois State Medical Society for the past 3 or 4 years and that no such case was referred to the committee during that period of time. The final stage is when the funds have organized their own wholly owned hospitals to be staffed by salaried physicians. When this situation has arrived, "beneficiaries" can go only to these hospitals and be treated by the doctors who work there. If they go anywhere else, they go at their own expense.

Dr. Mantz points out that this system of course does away with free choice of physi-

cian. Moreover, the family doctor has been completely eliminated from this type of practice. This is entirely contrary to the principles of medical ethics of the American Medical Association. It is therefore of the utmost importance that the unethical nature of this system of medical care be thoroughly explained to each individual member of the medical profession. Ethical concepts held by medical associations or other associations are of no value unless they can be enforced. Therefore, the American Medical Association and its constituent bodies must conduct an extensive campaign of education for their members explaining the evils of such systems of medical practice, and that those who cooperate in such plans are guilty of unethical practice. If all the forces of moral suasion and social influence do not suffice to deter physicians from participating in such schemes, the medical associations will have to consider legal methods. Obviously this calls for the best legal advice available. It might be that the recent action of the United Mine Workers Fund in condemning the general practitioners and not allowing the fund recipients to employ their services is a slanderous action, and it might be that medical societies could institute legal action on this basis. At any rate, this is a problem which must be faced by organized medicine, and if organized medicine submits to these various systems, the private practice of medicine on a fee for service basis is doomed. When the medical profession is controlled economically, it is then wide open for socialization, and the socialization of the practice of medicine will probably be the final step to socialization of our country.

Dr. Mantz does not mention the stand which has been taken by the Association of American Physicians and Surgeons in this connection. The AAPS for years has contended that the only way to meet such threats is for each individual physician to refuse to participate. There is nothing illegal in refusing to indulge in a practice which an individual considers immoral. Indeed, to engage in activities which a person considers immoral is itself immoral. Once again we come up against what can be the weakest link or the strongest link in the

chain—the moral integrity of the individual practicing physician.

Thomas Parker

One of Our Many 'Budget Busters'



Hesse in the St. Louis *Globe-Democrat*

Los Angeles, California, March 28. The operators of eleven drive-in restaurants were permanently restrained by the U. S. District Court from selling substitute products when patrons ordered Coca-Cola or Coke.

It seems to us that the Court might have gone a step farther and restrained everybody from filling their stomachs with any such bellywash, small, regular, or kingsize.

THERE IS SOMETHING YOU CAN DO ABOUT MENTAL HEALTH

By William C. Menninger, M. D.

Mental illness presents a tragic contradiction. No group of illnesses has a potentially higher rate of recovery. Most mental illness can be cured.

In spite of this proved fact, however, mental illness continues to be the nation's number one health problem—the neglected hinterland, the great blind spot of all health problems confronting our nation today.

Nearly half of all hospital beds in America are required for mental illness. Personality disorders were the largest single cause of manpower loss during the recent war. They were the reason for more than fifty percent of all the discharges from all military services.

The other aspects of the problem, namely, the shortage of trained personnel and facilities, is equally

serious. There are less than half the psychiatrists, one-fourth the psychologists, one-third the social workers, and one-fifth the nurses needed to meet the current demands of hospitals, clinics and other organizations desiring their services. The amount of money invested in research in the field of mental health is proportionately the smallest expended in any medical specialty. The need for treatment facilities, including both hospitals and clinics, is probably more acute than in any other medical specialty. Inadequate as it is, the treatment and care of the mentally sick patients represents the greatest dollar cost of any type of illness—approximately forty percent of all expenditures by the states for health and hospitals is made for the maintenance of patients in state mental hospitals. The whole problem is complicated by lack of public understanding. There is no field of medicine about which there are more misconceptions, misinformation, and downright ignorance. . . .

There are many things you can do about mental health in your community if you will. This means, however, that you have to be sufficiently mature to give yourself in time, energy and money. You will have to assume some social responsibilities in order that you, your family and your neighbors can have a richer life. If we are going to make any real changes in the status of mental health many of us will have to be more psychologically mature and more social-minded. If you wish to do something about mental health, you can go to work immediately in your own community. Align yourself with others who are interested in working for better mental health. There are mental health associations affiliated with the National Association for Mental Health in hundreds of communities across the country.

Join the mental health association in your community. Volunteer your help. All kinds of help is needed—hospital volunteers, professional assistance and guidance, technical help, speakers, organizers, campaigners, and, of course, financial contributions.

What could your association do? No community in the United States today fulfills all the requirements for good mental health; most of them fulfill very few. What about your community? Apply the following questions and see for yourself:

First, take a look at the medical facilities. Is there provision for adequate psychiatric out-patient care? Is there adequate local hospitalization for emergency cases? Is there a child guidance clinic, opportunity for marriage and parental counselling, vocational guidance?

How does your educational system meet the test? Is there some trained person to help the child solve his difficult problems in relations to his family, in relation to his school work, in relation to his playmates?

What is the status of delinquency and crime in your community? How much understanding is there that this is usually, if not always, a problem of mental health? What scientific understanding of human behavior is evident in your law courts, in the manage-

ment of prisoners, in the programs of the reform schools and in the rehabilitation efforts of the penitentiary?

What is the recreational program in your community? We have more leisure time than we had before, and apparently this is even increasing. We can't possibly ignore the fact that if we provide only alleys and beer taverns as playgrounds, juvenile and adolescent delinquency, yes, even adult crime will increase.

A direct and greatly needed attack on the problem of mental ill health would be the improvement of the mental hospital or hospitals in your state. Very few public institutions in the entire country can meet the minimum standards established by the American Psychiatric Association. Across the boards, our mental hospitals are twenty percent overcrowded with patients and sixty to eighty percent understaffed. In the great majority of our states the technique of placing a patient in the state hospital is medieval. Only as a result of the pressure of public opinion will commitment laws ever be changed. . . .

Certainly the world could never before have had more grief and unhappiness and human turmoil than currently exists. We—you and I—must assume some responsibility for reducing this turmoil. We have made such remarkable technological advances that we have become proficient in building great cities and the most complicated gadgets. We dare not continue letting our inability to get along with each other destroy our cities, our gadgets, ourselves. What gain to be scientific geniuses if we remain social imbeciles. The responsibility for achieving social and emotional maturity—which in turn depends upon preventing and treating mental ill health—lies entirely with you and me. What will you do about it?

THE FORAND BILL

Dear Doctor:

A bill now in Congress would place the health care of the aged and other OASI claimants under government supervision.

The Forand bill—H. R. 9467—would provide government hospital and medical care for about 13 million social security claimants by amending the Social Security Act. The AFL-CIO sponsored this bill and has given it top legislative priority.

The Forand bill is not in the public interest. There are several basic reasons why it is bad legislation for all Americans. These are:

1. It would bring the aged under government controlled and supervised health care. The government would set and enforce standards of health care under bureaucratic control, limiting the choice of hospitals and physicians.

2. It would eventually destroy private health insurance and the Blue Shield-Blue Cross plans.

3. It would introduce into the economy of the country, on a permanent basis, wage, fee and price fixing by government fiat.

4. It is national compulsory health insurance for a

segment of our population. Once established, this concept would be extended to all social security claimants. Ultimately America would have nationalized hospitals and medical care for everyone.

5. It is an attempt to solve a complicated health problem by political means rather than through established medical resources. Making the aged wards of the government with health care handouts is not the proper way to solve the problem.

6. It would mean higher taxes and less take-home pay for all wage earners for the benefit of a minority.

7. It could bankrupt the entire social security program and jeopardize the basic retirement incomes of millions of Americans.

Every physician must be prepared to oppose this bill vigorously and be ready to make his views known to the Congress should that become necessary.

So that you may be acquainted with this ill-conceived piece of legislation, the A. M. A. has prepared the enclosed pamphlet.

Meanwhile, some of the most important and respected organizations in the health field are preparing a program which will lead toward solution of the problems of health care for the aged. Announcement of this constructive plan will be made soon and details of the program will be supplied to you.

Your active support may be needed for legislative activities which will be carried out by state and county medical societies as required by developments in the Congress.

Sincerely,

David B. Allman, M. D., President
American Medical Association

FORM COUNCIL FOR HEALTH CARE OF THE AGED

The foundation was laid April 8 by some of the most important organizations in the health field to solve the problem of the health care of the aged.

For this purpose the American Dental Association, the American Hospital Association, the American Medical Association, and the American Nursing Home Association announced the establishment of the Joint Council to Improve the Health Care of the Aged.

Objectives of the council, the formation of which has been under consideration for some time by the sponsoring groups, were announced as:

"(1) To identify and analyze the health needs of the aged; (2) to appraise available health resources for the aged; and (3) to develop programs to foster the best possible health care for the aged regardless of their economic status."

The Joint Council to Improve the Health Care of the Aged is made up of three representatives of each sponsoring organization.

One of the first jobs of the council will be to determine exactly what are the health problems of the aged. Studies have been underway for the past several years by the organizations making up the council, but now, through joint efforts, research will be in-

tensified and projects for meeting the problem will be activated as rapidly as possible. The council will be the agency through which the efforts of the sponsoring member organizations will be coordinated to solve the health problems of the aged.

The sponsoring organizations pointed out that the need for new programs in this field is accentuated by the fact that the life expectancy of individuals has been constantly increasing in recent years. In 1935 life expectancy in the United States was an average 60.2 years. The most recent figure indicates the average life expectancy now to be 70.0 years.

The council will have as one of its principal immediate projects the development of programs and facilities to be tailored to the health needs and finances of the aged.

Another facet of the council's broad-range program will be to work closely with health insurance groups in an effort to improve the coverage of the aged and to see that their insurance dollars go further.

It is the belief of the Joint Council to Improve the Health Care of the Aged that much can be done for older people by the states and communities, and the council will endeavor to stimulate the activities at these levels of government.

Special research projects are contemplated by each of the organizations supporting the council. This research will then be pooled and programs developed to meet the health needs of the aged. The ultimate goal is to provide adequate health care at reasonable costs.

THE PHYSICIANS FORUM

Left-wing medical organizations have also been busy trying to persuade physicians to seek inclusion in the Social Security taxing system. Now that the Committee for the Nation's Health, Inc., the organization created and promoted by Michael M. Davis, has gone out of existence, The Physicians Forum, Inc., remains as the outstanding lobby both for the nationalization of medicine and the promotion of compulsory inclusion of physicians in Social Security.

One might overlook The Physicians Forum as being only a small Socialist-Communist group of physicians if it had not been successful in misleading the Medical Society of the State of New York. We may suppose that the Forum has also been effective in Connecticut, Ohio, California, and elsewhere. *When a small group which is not representative of the thinking of a large part of the medical profession is able to gain control of a State medical society, there is good reason to ask how they operate.*

Since The Physicians Forum has injected itself into a field of Federal legislation that would affect *everyone*, there should be broad interest in this particular lobby's operations. . . .

The Physicians Forum, Inc., having had little success during the past 18 years in its frontal efforts to force the nationalization of medicine, recently undertook a flanking movement. They put on a drive to

induce doctors to seek compulsory inclusion in the Social Security system. One would have thought that the reputation of The Physicians Forum and of its late leader, Dr. Boas, would have been sufficient to warn any American doctor against *anything* it might propose.

But the medical profession in New York State was either asleep at the switch or else did not care if medicine went down the Communist drain. In any event, The Physicians Forum put on an effective campaign for compulsory inclusion of self-employed physicians in Social Security. They issued a 4-page leaflet entitled *Social Security for Doctors*. In large type on the front page appears this question: "Why must a Doctor pay \$7,000 to \$25,000 *more* for retirement and life insurance than a Bank President does?"

Among the attractions held out to physicians by The Physicians Forum is the tremendous savings which a doctor will have if he obtains compulsory Social Security coverage. He is told that if he enters the taxing system at age 30, by age 65 he will pay \$7,371 Social Security taxes and will receive for himself and family benefits that would cost \$14,700 if purchased from a private insurance company. *On the other hand, if the doctor enters the system at age 60 he will pay only \$661.50 in taxes, but will receive \$26,000 in benefits for himself and family, says the Forum.*

The Physicians Forum does not explain that a doctor has just as good a chance of paying \$7,371 in Social Security taxes over a period of 35 years and of leaving only \$255 toward burial expenses to his estate. *The Forum does not spell out the fact that a doctor would not have any vested interest in Social Security. There is no Federal guarantee that he would receive anything.* Not a single doctor in the Nation would have a contract for any specified amount of life insurance or for any annuity of a given amount.

We should like to ask the doctors of New York if they would be suspicious of a slick salesman who tried to sell them a \$26,000 annuity and insurance policy for \$661.50?

We should further like to ask the doctors of New York State (or of any other State) if they really think they could save anywhere from \$7,329 to \$25,338.50 on insurance and annuities if they entered the Federal Social Security system? Do they suppose that the Federal Government has finally evolved a fiscal perpetual motion machine that will give *everyone* something for nothing? Are doctors gullible enough to believe that regardless of the age at which they begin paying taxes, be it 30 or 60, they will pocket thousands and thousands of dollars? Does it occur to any New York doctors to wonder how this miracle is performed?

We do not mean to imply that New York doctors are the only persons who have listened to glib salesmen for the Social Security system. The Connecticut State Medical Society also petitioned the American Medical Association to retreat from its long-time stand against compulsory inclusion of physicians in Social

Security.

Concluding this line of argument, The Physicians Forum, Inc., says: "This leaves the decision squarely up to you. You can get compulsory coverage if you want it, or you can get nothing at all. There's pretty clearly no middle course." . . .

If you are a physician perhaps you have received one of these Physicians Forum leaflets. Did it make your mouth water? Did you have visions of retirement annuities and life insurance policies for next to nothing? Did you think that possibly *you* could save "\$7,000 to \$25,000"?

If you are a physician living in New York you probably did have such visions because, incredible as it may seem, the New York State Medical Society actually asked the American Medical Association at its June meeting to rescind its opposition to compulsory Social Security for doctors of medicine. The State Society even used the Physicians Forum argument about physicians having to pay "\$7,000 to \$25,000" more for retirement and life insurance than other citizens do. . . .

How is it possible for a small group like The Physicians Forum to gain so much power over a State medical society? We can scarcely believe that the majority of New York doctors subscribe to the beliefs of The Physicians Forum. Or do the doctors of New York think maybe they can have their cake and eat it too? Do they think that maybe they can isolate themselves in one corridor of nationalized medicine's Alcatraz, the corridor where "free" ice cream and cake are given to the inmates?

Do they think they can avoid furnishing "free" medical services to the other inmates in the Socialist prison? Do they think they can somehow obtain Socialism's giveaways without in turn being compelled to make their contribution to the system? *What is a doctor's contribution to Socialism? Why, socialized, or nationalized medicine, of course.*

It is almost inconceivable that doctors would fail to see that The Physicians Forum connects retirement and insurance benefits under Social Security with Social Security medicine. The Physicians Forum fights for *both* parts of the Socialist program—benefits for doctors and services *by* doctors—all under one Socialist-Communist program.

Assuredly no doctor could believe that he would be able to pocket such benefits as might accrue to him under Social Security without at the same time doing his part under the system? *They will need to demonstrate they are not selfishly seeking the giveaways of Socialism while withholding their own fair share of labor under the Socialist system.*

Challenge to Socialism, July 18, 1957

NEWS

Members of the Anderson County Medical Society observed their annual Ladies Night program March

11.

Guest speaker for the occasion was Dr. Robert Lee Sanders, widely known Anderson County native who is now senior surgeon at Baptist Memorial Hospital, Memphis, Tenn.

Dr. Sanders spoke on "Kitchen Table Surgery and Medical Progress From 1906 to 1958".

Dr. Kenneth Merrill Lynch, president and dean of the faculty of the Medical College of South Carolina, has received the 1957 citation and medallion for outstanding service in the cause of cancer control at the spring meeting of the South Carolina Division, American Cancer Society, on April 1 in Columbia.

The citation and medallion is the highest honor bestowed upon any volunteer in the American Cancer Society's three-pronged program of research, education and service.

The president, Mr. Ward, said, "Dr. Lynch holds the unique position of being able to serve the cause of cancer control on all three of the American Cancer Society's fronts: education, service, and research. His contributions to all three vital phases of our work have been magnificent, and we are honored to have a man of his calibre and accomplishments among us."

The Frank Hilton McLeod Memorial Scientific Assembly was held on March 20, 1958 at Florence, South Carolina.

A program was presented by local physicians. The principal visiting speaker was Dr. Thomas M. Rivers, Medical Director of the National Foundation for Infantile Paralysis New York, N. Y. who spoke on "What's New in the Field of Viruses and Virus Research."

Donald W. Anderson, M. D. has announced the opening of his office for the general practice of medicine at 966 McCants Drive, Mt. Pleasant, S. C.

The Coastal Medical Society met on March 20, 1958 at Johnson's Fish Camp on the Edisto River. The scientific program was on "Coronary Disease" by Dr. Dale Groom, Charleston.

The WORLD HEALTH ORGANIZATION (WHO) with headquarters in Geneva, Switzerland, now groups 88 countries with the aim of protecting the health of all peoples. WHO works with national health services to prevent infectious disease (malaria, tuberculosis, syphilis, etc.), and to train health workers. It gives technical assistance to improve sanitary conditions in over 100 countries, warns of outbreaks of epidemic disease, co-ordinates research, and recommends international standards for drugs and vaccines.

Dr. M. G. CANDAU is Director-General, in charge of a staff (including field staff) of about 1000 professionals of 54 nationalities. WHO's budget, contributed by Member States, is \$13,500,000 for 1958.

WHO celebrates its 10th Anniversary this year at a Special Session of its governing body, the World Health Assembly, to be held in Minneapolis, beginning 26 May.

COLLEGE GETS MEDICAL GRANT OF \$34,825

The National Fund for Medical Education has awarded a grant of \$34,825 to the Medical College of South Carolina.

The local grant is part of \$3,178,825 awarded to this country's 82 medical schools.

The unrestricted grants are used chiefly to retain valuable faculty members, fill vacancies and institute new courses.

The Medical College received \$15,000 plus \$65 for each undergraduate student. There are 305 undergraduates enrolled.

Since the National Fund began making such grants in 1951, \$15,843,766 has been disbursed.

The fund was formed in 1949 under the leadership of President Dwight D. Eisenhower; former President Herbert Hoover, now chairman of the fund's board of trustees; and Dr. James G. Conant, former president of Harvard University and a former U. S. ambassador to West Germany.

SOUTH CAROLINA PHARMACEUTICAL FOUNDATION, INC.

The South Carolina Pharmaceutical Foundation was established recently by the South Carolina Pharmaceutical Association. It is incorporated as a non-profit Foundation.

The objects of the South Carolina Pharmaceutical Foundation are the advancement and promotion of the profession of pharmacy, encouraging the study of and research in the pharmaceutical sciences, cooperation with agencies charged with enforcement of laws and regulations relating to pharmacy, stimulating interest in activities which will advance pharmacy and the health professions.

The ten trustees of this Foundation, elected by the South Carolina Pharmaceutical Association, represent retail pharmacy, wholesale pharmacy, manufacturing pharmacy, educators, and hospital pharmacy. The current officers and trustees are:

President ----- J. Hampton Hoch, Charleston
Vice-President ---- James M. Plaxco, Jr., Columbia
Secretary ----- James M. Smith, Jr., Spartanburg
Treasurer ----- Elliott P. Botzis, Charleston
John F. Riley, Columbia; John M. Clark, Orangeburg;
Ross Langdon, Columbia; George Gentry, Starr;
Theo M. Holman, Isle of Palms; Donald James, Orangeburg.

PHYSICIANS AGAINST POLIO

Fourth shots are not considered necessary at this time. This was the consensus of Surgeon General Burney's polio advisory committee in Washington, March 21. Representatives of the AMA, the American Acad-

emy of Pediatrics, the National Foundation for Infantile Paralysis, public health departments and others agreed that the present three dose schedule provides ample protection *for the time being*. Individual physicians may decide to issue fourth shots when local outbreaks occur or when a patient is traveling to a place where polio incidence is high. In such cases, the fourth shot need not be given sooner than a year after the third shot. The decision to administer an additional shot, the committee felt, should be made by the individual physician.

Last year, many medical societies found that group inoculations—as one phase of local programs—helped immunize whole communities quickly, efficiently and thoroughly. By using this technique many societies finished up the job in a matter of days. Group clinics in almost every case boosted private office inoculations, earned excellent cooperation from volunteer agencies and quickly put the local polio situation in the realm of routine vaccinations. For those societies planning clinics for the pre-polio season, a handbook showing how some societies set up group programs is available.

Public emotion has run high on the polio inoculation problem, irritating some doctors to the point of exasperation. In spite of this feeling, the medical profession has assumed the leadership in the great majority of inoculation campaigns across the country. Many doctors write that they are enthusiastically backing up the polio drive. Let's keep in mind one thing: as long as it is in our power to protect our patients from a disease—in this case polio—it is our duty to see that they get that protection. There are currently 48.5 million Americans who still need to start their Salk series.

Julian P. Price, M. D.
Chairman, AMA Committee
on Poliomyelitis

MINUTES EXECUTIVE COMMITTEE OF THE STATE BOARD OF HEALTH FEBRUARY 1958

Dr. R. W. Ball, Director of the Crippled Children's Division, presented recommendations of the Crippled Children's Technical Advisory Committee, which were acted upon as follows:

It was moved by Dr. King, seconded by Dr. Smith, that dental fees be made commensurate with other surgery. Passed.

It was moved by Dr. Busbee, seconded by Dr. Camp, that burn cases not be accepted on the crippled children's program until the burns are healed (grafted). The orthopedist involved should review the case and pass on acceptability. Passed.

It was moved by Dr. Owens, seconded by Dr. Smith, that the following recommendation of the Crippled Children's Technical Advisory Committee be disapproved: "With the knowledge that there is a terrific backlog of cases in dire need of surgery and

hospitalization, it is the sense of the Technical Advisory Committee of the Crippled Children's Division, that the funds now being utilized to operate the summer camps be transferred to essential surgery and hospitalization services. The use of funds in this manner is believed to be in the best interest of the crippled children's program and the tax payer. It is recommended that the Legislature be requested to transfer these funds." Passed, to disapprove this recommendation.

Dr. McDaniel presented a proposed program for long term illness and problems of the aging. It was moved by Dr. Smith, seconded by Dr. King, that a demonstration home nursing program, as recommended in Dr. McDaniel's proposal, be set up. Passed.

Dr. McDaniel acquainted the Committee with the Staphylococcus infection prevalent in hospitals, and gave recommendations for control.

It was moved by Dr. Hanckel, seconded by Dr. Caup, that a bill to regulate the cleaning of septic tanks, brought to the attention of the Committee and discussed at this point, be approved. Passed.

The matter of tourist court regulations was presented. On motion of Dr. King, seconded by Dr. Camp, the recommended regulations were approved by the Committee, provided the Attorney General feels such regulations are necessary. Passed.

NEW SERVICE TO MEDICAL COMMUNICATIONS DEVELOPED

An extraordinary new service has been developed for both medical communications and medical education.

For the first time, the most outstanding scientific exhibits at major annual medical conventions are being preserved. This is being done on film strip, using the latest audio-visual technics.

Every medical college, teaching hospital and county medical society is being offered the opportunity to start building its own "library" of filmstrips.

In preliminary showings to physicians, the "Exhibits-On-Film" have been called "better than being there". (When the outstanding scientific exhibits are put on filmstrips, in full color, with sound, considerable data is added; and the exhibiting physicians answer many of the questions asked by physicians who have seen the exhibits at the particular conventions. One of the first in the new library includes recordings of heart sounds associated with various abnormalities.)

Contact Executive Secretaries

Individual physicians who wish to see the first filmstrips are asked to contact the executive secretaries of their county medical societies. Hospital personnel are asked to contact their superiors, who may check either with the nearest college library or county medical society.

Complete Libraries will be made available on a continuous and permanent basis to any medical college and county, state or regional medical society which requests this service, from Helen Martin, Executive

Secretary, "Exhibits-On-Film", Lakeside Laboratories, Inc., 1707 E. North, Milwaukee 1, Wisconsin.

This "permanent contribution" to medical communications is free.

SMALLPOX BROUGHT INTO 18 COUNTRIES BY INTERNATIONAL TRAVELERS

No less than 18 countries were infected with smallpox by international travelers last year, and as a result eight of them suffered epidemics of this quarantinable disease, according to the World Health Organization Committee on International Quarantine.

At a recent meeting in Geneva, the Committee warned against any relaxation of vaccination measures against smallpox and called for the use of potent vaccines as well as correct vaccination procedures. Moreover, the Committee stressed the need for medical and other personnel who come in contact with travelers to maintain a high level of immunity against smallpox by repeated vaccination. In the course of these epidemics, some doctors treating tourists caught the infection and died.

The WHO experts also drew attention to the advantages of dried smallpox vaccine for mass campaigns. Dried vaccine is easily transportable, remains effective without refrigeration and does not spoil, even in the tropics.

ANNOUNCEMENTS

MOUNTAINTOP MEDICAL ASSEMBLY WAYNESVILLE, N. C. JUNE 19, 20, 21, 1958

THURSDAY, JUNE 19TH

- 9:30 A. M.—Dr. Willis Hurst, Emory University, Atlanta—"Cardiology - Diagnostic Points, Part 1."
- 10:15 A. M.—Dr. Joseph H. Patterson, Emory University, Atlanta—"Renal Diseases and Disorders in Children."
- 11:00 A. M.—Intermission
- 11:15 A. M.—Colonel James B. Harteering, Walter Reed Army Medical Center, Washington—"The World Wide Fall-Out of Nuclear Fission Products."
- 12:00-12:30—Question and Answer Period.
- 2:30 P. M.—Dr. Edward Compere, Northwestern University, Chicago—"Whiplash Injuries of the Neck."
- 3:15 P. M.—Dr. Robert Dickey, Foss Clinic, Danville, Pennsylvania—"Common Dermatoses Seen in Office Practice."
- 4:00 P. M.—Intermission.
- 4:15 P. M.—Dr. Joseph H. Patterson—"Chest Diseases in Childhood."
- 5:00—5:30—Question and Answer Period.

EVENING SESSION

- 8:00-9:30 P. M.—Audiovisual Program: Films: Subjects to be announced at morning and afternoon session.

FRIDAY, JUNE 20TH

9:00 A. M.—Dr. Edward Compere—"Upper Extremity Fractures."

9:45 A. M.—Dr. Robert Dickey—"Dermal Manifestations of Diabetes Mellitus."

10:30 A. M.—Intermission.

10:45 A. M.—Dr. Willis Hurst—"Cardiology Diagnostic Points, Part II."

11:30-12:00—Question and Answer Period.

SATURDAY, JUNE 21ST

9:00 A. M.—Dr. George Crile, Jr., Cleveland Clinic, Cleveland—"Changing Concepts in the Nature of Cancer."

9:45 A. M.—Colonel James B. Harteering—"The Response of Man to Ionizing Radiation."

10:30 A. M.—Intermission.

10:45-11:30 A. M.—Dr. George Crile, Jr.—"Cancer of the Thyroid and Breast."

(Sponsored with the help of Wyeth Laboratories, Philadelphia, Pennsylvania.)

The AMA pamphlet "Are You Fit To Drive?" has been distributed widely and additional copies are available.

A method of sale and distribution of the pamphlets has been worked out. All orders for pamphlets should be directed to:

Association of Casualty and Surety Companies
60 John Street
New York 38, New York

The price is \$4.60 per 100 copies regardless of quantity.

The Commission on Education of the American Academy of General Practice, has approved the

Obstetric-Pediatric Seminar
which is held annually at
Daytona Beach, Florida,

for 15 hours Category I for 1958.

The dates of the Seminar this year are September 8, 9, 10, 1958.

Anyone going to the
AMA Meeting, San Francisco,
June 23-27, 1958,

might wish to write to:
Moyers Travel Bureau
34-38 Peachtree Street
Atlanta, Georgia

about special arrangements for the "AMA Convention Special."

**NOTICE TO FORMER GRADY HOSPITAL
HOUSE STAFF**

An organization is being formed which is to be composed of all former members of the House staff of Grady Memorial Hospital in Atlanta. Two years ago, letters were sent to all known former House Officers. However, we know many names were not included because of an incomplete mailing list. If you

did not receive a notice or failed to reply for any reason please notify our office and let us know your name, address and when you were at Grady. Plans are now being made for our first Annual Meeting next fall.

Address: Grady Hospital Clinical Society
Office: G-610
80 Butler Street, S. E.
Atlanta, Georgia

GOLF TOURNAMENT

The American Medical Golfing Association is holding its annual golf tournament in conjunction with the A. M. A. Convention June 23, 1958 at the beautiful Olympic Lakeside Golf and Country Club, San Francisco, California. This will be a whole day of rest and relaxation with golf, luncheon, banquet, and a prize for everyone. We have left no stone unturned to assure you the very best. Tee off time 8 A. M. to 2 P. M. We cordially invite all golfing doctors to attend. Handicaps scratch to 30 in flights.

For information, contact James J. Leary, M. D. Secretary, 450 Sutter Street, San Francisco, California.

**UNIVERSITY OF MICHIGAN
SCHOOL OF PUBLIC HEALTH**

Ann Arbor, Michigan

The Maternal and Child Health Fellowships are again being made available to us by the Children's Bureau.

These fellowships are intended for physicians, nurses, nutritionists, and social workers who wish to prepare themselves for administrative or consultative posts in the broad field of maternal and child health. They are designed to cover all tuition and academic expenses and to provide a reasonable living allowance during residence at the University and during the period of assigned field work.

We will be happy to furnish any candidates with any additional details which they might like to have.

**SCHOOL OF PUBLIC HEALTH
UNIVERSITY OF NORTH CAROLINA
DEPARTMENT OF MATERNAL AND CHILD
HEALTH
ANNOUNCEMENT OF FELLOWSHIP
IN MATERNAL AND CHILD HEALTH**

The Department of Maternal and Child Health of the School of Public Health of the University of North Carolina wishes to announce again the availability of a fellowship in maternal and child health for the academic year commencing in September 1958. This fellowship is available to a physician enrolling in the School of Public Health, and undertaking a program of study leading to the degree of Master of Public Health with specialization in maternal and child health. Candidates should have had specialized training in pediatrics or obstetrics and be graduates of an approved School of Medicine. At

least two years of actual experience in a public health program dealing with some phase of maternal or child health may be acceptable in lieu of formal pediatric or obstetric training.

This scholarship fund, in the amount of five thousand dollars (\$5,000), is made available to the School of Public Health through the cooperation of the North Carolina Board of Health and the Children's Bureau of the Department of Health, Education, and Welfare. Physicians interested in this fellowship should apply to the Chairman, The Admissions Committee, School of Public Health, University of North Carolina, Chapel Hill, North Carolina, as early as possible. The award is usually made about July first.

PERSONALITIES

WESTMINSTER DOCTOR LOOKS BACK

Dr. W. A. Strickland, Westminster's oldest doctor, can look back on 1957 with fondest memories. It was in this year that he celebrated the 50th anniversary of his marriage and also rounded out 50 years of service as a practicing physician.

"I have no idea of retiring," said the pleasant mannered, soft spoken doctor. "I shall continue in active work as long as I'm worth anything to my family and my community."

Dr. Strickland is keenly interested in community affairs. He has served as a member of Town Council for six years, though he did not offer for reelection in the recent election, and he served as a member of the Public Service Commission for 16 years. He is a deacon and trustee of Westminster Baptist Church; was for a number of years a member of the local school board, and also served on the County board of education for several years.

Those were the "horse and buggy days" for sure. Dr. Strickland well remembers bouncing over the rough, red roads of mountain communities on his way to patients. He was the proud owner of the second automobile actually used in town. Many of the names of cars he literally wore out are remembered by few today: "Baby Maxwell," the Overland, the Elcar and the Dixie Flyer.

Not only was transportation primitive. Dr. Strickland recalls that, in the early years of his half century of practice, doctors sometimes performed operations in the homes of patients.

In the course of his practice, Dr. Strickland has attended some 3,000 deliveries and performed uncounted tonsillectomies. He is the only doctor in the county who has had special training in diseases of eye, ear, nose and throat.

BLACKVILLE DOCTOR RAISES CAMELLIAS

Camellia bushes as thick as cotton plants in a field is a pretty good way of describing Dr. O. D. Hammond's backyard hobby.

He has over 2,000 seedlings, and about 300 varieties of camellias planted in back of his house.

His wife says that she is not going to give him more space in which to plant. "He has just about taken all of the yard now."

Actually it was Mrs. Hammond who first got interested in growing the beautiful plant about 18 years ago. Dr. Hammond, a comparatively newcomer to the hobby that some people spend a lifetime on, has only been interested in growing camellias since 1950.

But the doctor, who has been practicing medicine in this community for over 50 years now, said he has always taken his hobbies seriously and gone into them in a big way. "Fishing for example, which I did pretty regularly until 1950: I like to have ruined my practice fishing. They used to have to come to the river bank to get me to deliver a baby."

In their yard the Hammonds have about 700 blooming-size camellias.

When Dr. Hammond planted his first camellia bushes he bought 103 plants. That was in 1950. "Ninety-seven were killed." Since then his luck has all been good with the plants.

Mrs. Hammond said her husband knows what he is doing with the plants because "he works and studies them all the time."

The doctor, who has delivered triplets once, two sets of twins in one night at another time, five babies in one night plenty of times and close to 7,000 babies in all, said he has only one philosophy with anything he does "Just hard work. Take fishing, there's nothing harder than fishing if you do it right."

Charleston News and Courier

DR. L. L. RICHARDSON

Folks in this lower Greenville County town — its limits extend one mile in any direction — don't believe there is such a thing as "too much." And because they do believe it, Dr. L. L. Richardson has been re-elected mayor and began his 42nd year in that capacity January 1, 1958.

Every two years this town of Simpsonville of some 2,000 residents has voted and every time Dr. Richardson has been the man mostly without opposition. Folks hereabouts say they just know a good thing when they see it.

But mind you, this "country doctor" isn't the kind who has spent his entire life in small town politics. He was 49 years old before he decided to get into the political swim.

Lawrence Lafayette Richardson, M. D., Mayor, and an All-Around-Grand-Old-Fellow, was 90 years old back in July. He was born two years after the War Between the States and has been practicing medicine for 64 years "If I make it until March 6 of next year," he says.

"Doc" has been the only mayor to ever hold office in Simpsonville. His actions speak enough for citizens to realize they don't need another man.

CHESNEE'S DR. SAM REID NAMED
PHYSICIAN OF '57

Dr. Sam D. Reid of Chesnee, "proudly, a plain country doctor," treasured the highest tribute his fellow physicians can pay him.

Spartanburg County Medical Society announced him as Doctor of the Year at its annual Christmas dinner and dance in Memorial Auditorium in December.

Making the presentation was Dr. J. C. Josey of Spartanburg, retiring Doctor of the Year and new president of the Society.

The trophy and tribute, accolading Dr. Reid as outstanding physician in the affection and esteem of hundreds of doctors and surgeons, found him "surprised" and "deeply and humbly grateful."

Sharing the spotlight with the modest general practitioner were his wife and several members of his family.

Dr. Reid was born in Gowansville section of upper Spartanburg County, the son of the late W. J. and Lula Noe Reid.

He was farm reared, "raised up out in the country" as he put it during a post-award interview.

His formal education began at North Greenville Academy on the Tyger River, "that was high school," he said. He received his B. S. degree from Furman University in 1922 and his Doctor of Medicine degree from the Medical College of South Carolina in 1926, interned at Mary Black Hospital and hung up his shingle for general practice at Chesnee in the fall of 1927.

His long service has been performed in rural and mill communities, including remote sections and humble homes and thousands of day and night trips over rough roads, "wherever people needed me."

He has delivered some 6,000 babies and is well into his second generation of patients "tended to."

Dr. Reid is new vice president of the Society. Other officers, in addition to him and Dr. Josey, are Dr. J. E. Raybourne, secretary, and Dr. Porter Crawford, treasurer. All were recently elected.

Dr. A. S. (Bill) Pearson of Woodruff is retiring president.

Fourteen percent of all A. M. A. physician members in the U. S. have had a medical professional liability claim or suit brought against them. The highest percentage is in California with 1 out of 4 and the lowest is in South Carolina with less than 1 out of every 33.

Approximately 18,500 living physicians in the United States have had a claim or suit brought against them at some time. However, 40% of these claims and suits have been dropped or decided in favor of the physician.

NEONATAL LAMENT

(Apologies to Lord Tennyson, especially)

Comrades, leave me, here, a little

While as yet tis early morn
In my neonatal wakings
Must I be so rudely shorn?

Must I lose my virgin foreskin,
To the surgeon's eager knife?
Must I have a smegma-phobia,
Spreading cancer all my life?

More I fear the strong ammonia
Burning deep my tender glans
Or instead the thick adhesion
Made by obstetrician's hands.

But my foreskin, short or longer,
Irks the keen obstetric glance.
Off must it come without a thought
Of battered glans within my pants.

Are my shrieks psychosomatic?
Can I spare the flowing gore?
Take, oh take your fee, my doctor
But leave my foreskin evermore.

J. I. W.

THE DUEL BETWEEN DR. HALEY AND
DELANCY

The political discussions were revived with much warmth and irritation, in consequence of the non-importation and non-consumption restrictions, and continued exactions that were opposed by the colonists, but could not be resisted. In 1771, on the 16th of August, an altercation arose, at a genteel house of entertainment in St. Michael's alley, between Dr. John Haley and Delancy, an elegant, accomplished royalist, of New York, a brother of Mrs. Ralph Izard. Delancy being irritated, probably from being foiled in argument, insulted Dr. Haley, by giving him the "lie". Haley immediately challenged Delancy to fight with pistols at that house, and proposed that they should go together to an upper room, alone, and without seconds. Delancy accepted the challenge, and the proposed arrangement. He took one of the pistols offered to him by Haley; they fought across a table, fired at the same moment, and Delancy was killed.

Dr. Haley was an Irishman by birth, an eminent practitioner of medicine in Charleston. He warmly espoused the popular cause in opposition to royalty, and, as a man of education and influence, was much encouraged by the leaders of the incipient revolution. Delancy being a very distinguished man among the royalists, much irritation was exhibited among them, at his death, and the circumstances attending it. The whigs, on the other hand, defended Dr. Haley, and concealed him until his trial came on. During this concealment, being secluded from society, and deprived of his usual occupations of mind and body, he became melancholy, and this depression was increased by an accidental occurrence that took place while he was in this seclusion. In passing, after dark, across the

enclosure where he stayed in the country, a clothes-line, which had been left extended and unseen, suddenly caught him by the throat, and stopped his course. He considered this to be ominous of his fate, and the impression could not be dispelled by the reasoning or the jokes of his friends. He may have imbibed superstitious fears from nursery tales in his youth, which sometimes, even in manhood, embitter the feelings. The firmest minds have their moments of weakness, and, in his situation, such depression might be expected. Dr. Haley knew that, having fought without witnesses and killed his opponent, the laws of his country and the usages of courts considered him a murderer, and that he must be tried for his life. His cause, however, had been taken up as a party dispute. Thomas Heyward, the Pinckneys and the Rutledges defended him in his trial. They proved that Delancy was the aggressor; that he not only accepted the challenge, but the terms also; that he took Haley's offered pistol, and voluntarily followed him up stairs into a private room, as had been proposed; that he fired with intent to kill Haley with his own pistol, for the two balls with which it was loaded were taken out of the wall just back of his adversary, one on each side of where he stood. Haley was acquitted, and his acquittal was considered a great triumph by the whigs and popular party, situated as they were under the royal government. It was also considered by the royalists a proportionate source of chagrin.

—Johnson's *Traditions of the American Revolution*

Medical Ensigns Aboard Ship

"The Medical Ensign Program is now in its seventeenth year of operation. We, the Medical Ensigns, belong to the inactive reserve; we receive pay when on active duty during the summer, and during our senior year if we are enrolled in the Navy's Senior Medical Student Program. As a rule we were not members of an ROTC during our undergraduate training. From the student's point of view the reasons for joining the Navy Program are to prevent coasting along until called up by the selective service, to insure future service with the Navy (preferred over the Army and Air Force), and to begin a possible naval career at an early age.

If you're wondering why you've never seen us around before, it is because prior to this summer of '57 a medical student who was interested in the Navy was offered only shore billets at a limited number of naval research installations and naval hospitals. Taking the long view, naval planners found this to be inadequate. A doctor who enters the Navy today scrambles from a hectic internship headlong into a year of sea duty for which he is unprepared, knowing nothing of the ships or the men on them. This summer 50 Medical Ensigns were authorized as a test group to go to sea to gain knowledge of the seagoing Navy.

We have the opportunity to familiarize ourselves with the medical problems and facilities afloat of the modern Navy, to absorb as much as we can of all phases of the seagoing Navy with the purpose of creating a better understanding of how we particularly fit into the scheme of things, and of developing an appreciation for the work of the Navy personnel afloat so that we may better understand and treat them in naval hospitals and to enjoy a memorable Midshipman Cruise.

Besides our duties in the Medical Department we are being introduced to all the departments on this man-of-war by means of lectures, on the spot observations, and limited participation in activities such as taking the helm of the Forrest-Royal, we've toured all supply's spaces, perused their records, and noted its particular function under medical scrutiny. We've ridden in the 5 inch mounts during firing practice, participating in Captain's inspection, saw the grandeur that was Rio and the Shore Patrol; lunched and laughed with Admiral McManes; experienced *mal de mer* and *esprit de corps*, simultaneously aboard "Tin cans"; been picked up by the sling of the whirlybird; met with the Captain, Exec, and heads of departments to listen to their sea stories as well as their sincere feelings concerning duty, their careers, and their Navy lives. All in all, we are enjoying the manifold experiences which constitute our indoctrination from epsom salts to Navy salts." (Ensign Kenneth C. Morley, Jr., 1995 (Medical) USNR: "The Postrider" —USS NORTHAMPTON)

Medical News Letter, Nov. 22, 1957

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. B. J. Workman, Woodruff

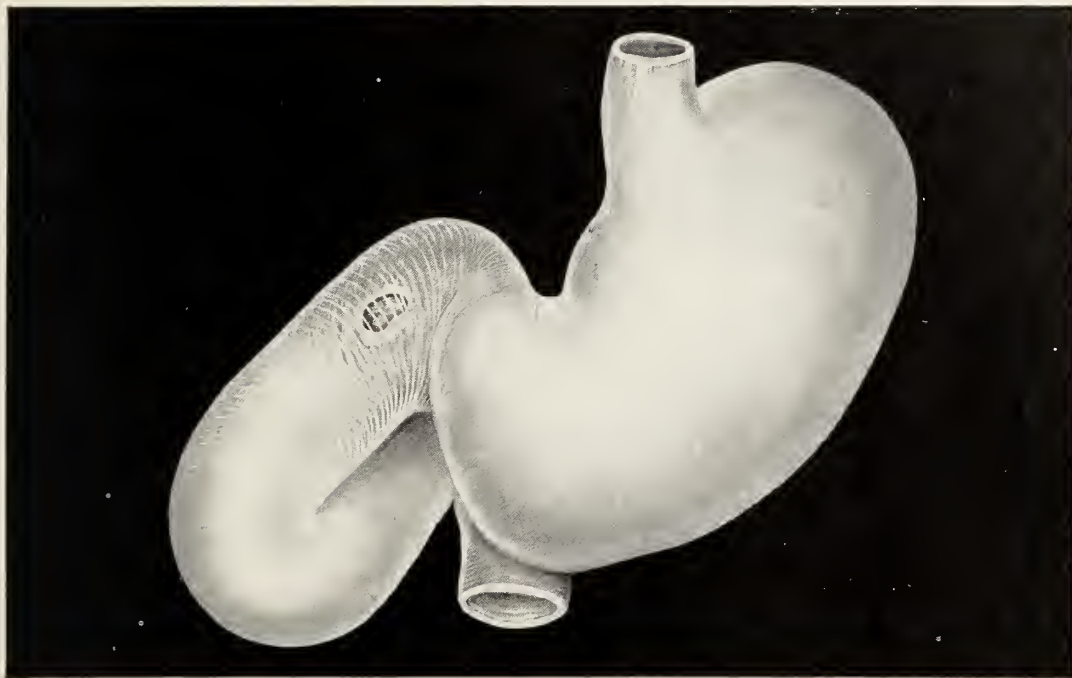
Bulletin Editor: Mrs. Leon Banov, Jr., Charleston

A cordial invitation is extended to all members of the Woman's Auxiliary to the A. M. A., their guests and guests of physicians attending the A. M. A. convention to participate in all social functions and attend the general meeting of the Auxiliary.

This 35th annual convention of the Woman's Auxiliary is being held concurrently with the A. M. A.

meetings June 23-27 in San Francisco. Headquarters will be at the Fairmont Hotel and tickets for the various social events will be available at the registration desk. There will be a hospitality room (the Green and Empire Rooms) on the first floor.

Mrs. Paul C. Craig, president of the National Auxiliary will preside at most of the sessions and Mrs. E.



Pro-Banthine® “proved almost invariably effective in the relief of ulcer pain,

*in depressing gastric secretory volume and in inhibiting gastrointestinal motility.”**

“Our findings were documented by an intensive and personal observation of these patients over a 2-year period in private practice, and in two large hospital clinics with close supervision and satisfactory follow-up studies.”*

Among the many clinical indications for Pro-Banthine (brand of propanthelene bromide), peptic ulcer is primary. During treatment, Pro-Banthine has been shown repeatedly to be a most valuable agent when used in conjunction with diet, antacids and essential psychotherapy.

Therapeutic utility and effectiveness

of Pro-Banthine in the treatment of peptic ulcer are repeatedly referred to in the recent medical literature.

Pro-Banthine Dosage

The average adult oral dosage of Pro-Banthine is one tablet (15 mg.) with meals and two tablets at bedtime.

G. D. Scarle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

*Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthine in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastroscopic Studies. Report of 60 Cases, Am. J. M. Sc. 232:156 (Aug.) 1956.

SEARLE

Arthur Underwood, president-elect will succeed her in office. Both officers will be honored guests at a tea and fashion show scheduled for Monday, June 23 at 3:30 at the Mark Hopkins Hotel.

Among the convention highlights will be addresses by Dr. Gunnar Gundersen, president of the A. M. A. and Dr. David B. Allman, immediate past president. Their talks are scheduled to be given at luncheon on Wednesday.

The Woman's Auxiliary to the American Medical Association has encouraged automobile safety, the nurse recruitment program and increased contributions to A. M. E. F. this year. At the convention, the Woman's Auxiliary to the S. C. Medical Association's report will be given, pointing out the progress made with this program. Last year, Auxiliary members in S. C. collected more than \$2300 in the interest of A. M. E. F.

Mrs. B. J. Workman of Woodruff, S. C. has been president of the State Auxiliary, Mrs. George Orvin of Charleston, president-elect.

Special features at the A. M. A. meeting will be the PREMIERE RECRUITMENT FILM (title to be announced) Paramedical careers film made under the direction of the American Medical Association and the American Hospital Association, with the cooperation of Squibb and Company.

Introduction, Dr. Gunnar Gundersen, President, American Medical Association and a Tour of San Francisco homes.

Outstanding homes with beautiful views of San Francisco Bay have been chosen for this House Tour. Gray Line buses (included in ticket charge) will leave from Union Square and Hotel Fairmont. Tickets available at Auxiliary Headquarters and A. M. A. registration booth.

BOOK REVIEWS

CURRENT THERAPY 1958—by numerous contributors. Edited by H. F. Conn, M. D. W. B. Saunders, Phila—1958. Price \$12.00.

The rapid changes in medical knowledge and in the techniques of treatment require frequent summary consideration. This is accomplished well by the publication of *Current Therapy*, a most useful volume which has appeared annually since 1949. Its 827 pages cover treatment only. The articles are brief and to the point. Format and index are good.

This might well be a standard desk reference book for every practitioner.

J. I. W.

PROGRESS IN PSYCHOTHERAPY (Volume II. Anxiety and Therapy) Edited by Jules H. Masserman, M. D. and J. L. Moreno, M. D. Grune & Stratton, New York, 1957—Price \$7.50.

This second volume on psychotherapy, like the

first, is a collection of specially written articles by not too many authors. It deals with the two important features of psychotherapy—anxiety in the patient and the cultural setting in which the patient lives. Stated this way the book implies, by dealing mainly in these two areas, that all psychotherapy must include a psychological study of an individual's unique anxiety system and an anthropological study of his total social background.

The first part of the book takes up the problem of anxiety in the patient. It is shown clearly that basic anxiety is a normal, value-producing experience in living, that it in itself is not of physiological origin and therefore is not the same as its physiological concomitant, tension. This simple statement from the book on this matter typifies the whole tone, "First the goal of therapy is not to free the patient from anxiety. It is rather, to help him become free from neurotic anxiety and to help him meet normal anxiety constructively. Normal anxiety is an inseparable part of growth and creativity."

In regard to the use of drugs and other organic aids it states, "The harmful effects of the general use of drugs for normal anxiety is obvious, for to wipe away the anxiety is in principle to wipe away the opportunity for growth, i. e. value transformation, of which the anxiety is the obverse side. By the same token, neurotic anxiety is a symptom of the fact that some previous crisis has not been met."

The second part of the book specifically deals with the problem of the presence of various schools of psychotherapeutic thought. The main concern here is a trend in a few schools of thought to depart from the basic principle that it is for the individual patient (not the mass of patients) (who constitute and form the neurotic values of large social groups) that psychotherapy exists.

This essentially presents the main problem of all psychotherapy. Should we emotionally re-educate the individual or should we confine our effort towards emotionally re-educating the public. The tenor of the book suggests clearly that the individual approach is the primary process and that the social or "cultural approach" is an accompanying, but secondary, phase of all psychotherapeutic effort.

Norton L. Williams, M. D.

CLINICAL HEART DISEASE—by Dr. Samuel A. Levine, M. D., Clinical Professor of Medicine, Harvard Medical School; Physician, The Peter Bent Brigham Hospital and New England Baptist Hospital. 673 pages. Philadelphia: W. B. Saunders Company, Publisher, 1958. Price \$9.50.

Since the introduction of the first edition of this text in 1936, it has become a deservedly popular one for medical students and practitioners interested in cardiology. As in the previous editions, no attempt has been made to cover the field of cardiovascular disease completely, but neither is this a bare synopsis.

Rather, Dr. Levine has again presented an easily readable and practical series of discussions of the essential aspects of cardiovascular disease, the format remaining essentially the same as in previous editions.

The major revisions are found in the new chapter on congenital heart disease by Dr. Alexander Nadas, a brief summary of the more important anomalies by an authority in the field of pediatric cardiology; and in the chapter on electrocardiography now written by Dr. Harold D. Levine. This latter section consists of 232 pages of a well illustrated survey of the essentials of this field, remarkably comprehensive for a text of this type, and can be highly recommended.

The remainder of the text has been brought up to date, though, as in previous editions, no bibliography or illustrations have been utilized. It will undoubtedly continue to be a favorite of the student and practitioner interested in a fairly fundamental, practical, and eminently readable approach to this subject.

Frederick E. Nigels, M. D.

GENERAL TECHNIQUES OF HYPNOTISM. 1st Ed. By Andre M. Weitzenhoffer, Ph. D. 434 pages; Grune and Stratton, Inc., New York. 1957. Price \$11.50.

The rising interest in the use of hypnotism in medicine and dentistry has led to the publication of many reviews of this subject in recent years. The present volume is a very comprehensive coverage of the origin, development, and presently used technique. Dr. Weitzenhoffer, a clinical psychologist, has written this book in text book style primarily for reference in actual courses in hypnotism.

The subject matter is divided into three parts: (1) The foundations and dynamics of hypnosis; (2) Waking suggestions, dealing primarily with individual suggestibility to hypnosis, and (3) Hypnosis and methods of induction. Much stress is laid on actual transcript of the therapists induction of hypnosis in patients, pitfalls, and dangers inherent in the procedure. The applicability of the procedure to medicine, however, is not discussed.

The material is presented at great length and in too much detail for readers other than those who wish to make a special study of hypnosis. This book cannot be recommended for the practicing physician and would seem to have little value as a reference work.

Charlton deSaussure, M. D.

THE MALABSORPTION SYNDROME. 1st Ed. Mount Sinai Hospital Monograph, David Adlersberg, Editor, 250 pages. Grune and Stratton, New York. 1957. Price \$5.50.

This is a collaborative effort by nineteen members of the staff of the Mt. Sinai Hospital on the pathological physiology, diagnosis, and treatment of non-tropical sprue, coeliac disease or idiopathic steatorrhea, all being the same disease, and termed the "Malabsorption Syndrome."

The normal physiology of fat, protein, and carbohydrate absorption is first covered and then on the basis of this, the individual abnormalities noted are discussed both as to etiology and treatment. Diagnostic techniques including x-ray, small intestinal biopsy, and radioactive tracer studies of fat are well described, and application even beyond the entity of the malabsorption syndrome is elucidated. The hematological changes produced are well covered and give insight into the pathogenesis of the group of anemias due to faulty intake of essential hemopoietic factors.

The treatment is very well covered from the point of dietary control, drug therapy, and steroid management as well as the correction of the electrolyte imbalance.

This monograph can be well recommended for the student or physician interested in gastro-intestinal disease and is a valuable reference work for all to have available.

Charlton deSaussure, M. D.

NOISE AND YOUR EAR by Aram Glorig, M. D. Grune & Stratton, Inc., New York. 1958. Price: \$6.50.

Aram Glorig, Jr., M. D., Director of Research, Research Center of The Subcommittee on Noise in Industry, and a member of the Committee on Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology has given us in his monograph, "Noise and Your Ear", a very clear and comprehensive coverage of a complex and often confusing subject.

The author traces the problem of noise (defined as "any unwanted sound") and particularly noise in industry as a major producer of deafness, from the beginning of the Industrial Era at the turn of the century up to the present time. He covers such matters as the development of compensation laws for the benefit of the worker and the part that the physician plays in industrial communities. The anatomy of the ear, the theories of hearing, audiometry and other tests to determine the extent of hearing loss are presented with a maximum of clarity and minimum of words.

This monograph is especially recommended to those physicians who have to cope with noise in industry.

R. W. Hanckel, M. D.

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JOURNAL SOUTH CAROLINA MEDICAL ASSOCIATION
Charleston, South Carolina

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South Carolina Medical Association

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NUMBER 6

COMMON PROBLEMS IN PREMALIGNANT AND MALIGNANT DISEASE

Panel Discussion Presented On Founder's Day At
The Medical College of South Carolina
November 7, 1957

MODERATOR

John C. Hawk, Jr., M. D.: Associate Professor of Surgery and Director of Cancer Clinic, Medical College of South Carolina.

PANELISTS

Jerome A. Urban, M. D.: Attending Surgeon, Memorial Hospital; Assistant Clinician, Sloan-Kettering Institute; Instructor in Surgery, Cornell University Medical College.

J. Elliott Scarborough, M. D.: Director of the Emory University Hospital; Associate Professor of Surgery, Emory University School of Medicine.

Theodore R. Miller, M. D.: Associate Attending Surgeon, Memorial Center for Cancer; Surgeon, Pack Medical Group; Instructor in Surgery, Cornell University Medical College.

Charles C. Harrold, Jr., M. D.: Assistant Attending Surgeon, Head & Neck Service, Memorial Hospital; Associate Attending Surgeon, Roosevelt Hospital; Instructor in Surgery, Cornell University Medical College.

M. Lois Murphy, M. D.: Assistant Professor of Pediatrics, Cornell Medical School; Assistant in Pediatrics, Memorial Center, New York, and Sloan-Kettering Institute.

Edward F. Parker, M. D.: Clinical Professor of Surgery, Medical College of South Carolina.

Harold S. Pettit, M. D.: Clinical Professor of Radiology, Medical College of South Carolina.

John T. Cuttino, M. D.: Dean of the School of Medicine, and Professor of Pathology, Medical College of South Carolina.

SUBJECTS DISCUSSED

Hemangioma and Lymphangioma
Premalignant and Malignant Skin Lesions
Cancer of the Breast
Thyroid Nodules
Leukoplakia

Post-operative X-ray Therapy in Lung Cancer

Dr. Hawk: I don't know whether you all know the function of the moderator of a panel. I recently heard that a moderator is supposed to be like a eunuch in a harem: he is supposed to be around all the time, but is not to take any active part in the proceedings. Now, I don't want to be completely emasculated on this panel, and I will have to direct it to a

certain extent, but as far as the "dropping of pearls" is concerned, we shall hope that they will be dropped by our panelists, and we are looking forward to this.

You have all had distributed to you a protocol giving briefly the histories on several patients whom we will present to you. The first case is that of a Negro girl seen in the Cancer Clinic on October 26, 1955 at the age of six months with a history of the appearance of a small red lesion of the skin overlying the left mandible at the age of one month. This gradually increased in size. In the first slide (Fig. 1) we see the appearance of this lesion



FIGURE 1

at the time the child was originally seen in October 1955. I think we may have a great deal of difference of opinion as to how this child should have been treated, or whether the child should have received any treatment at all. Actually, this child was treated by sodium morrhuate injections on only four occasions. We will now bring in the child so that you can see the progress of the disease. I think you can see that this little child still has extensive swelling. Those members of the panel who would like, may examine her. The reddened element, I believe, has largely disappeared.

Dr. Parker: Are there any lesions elsewhere on the body?

Dr. Hawk: There are no other lesions. This is the only lesion.

Now while the other members of the panel are examining this child, we will give briefly the history of a smaller lesion on a two months old Negro baby who is in Roper Hospital at the present time by virtue of having an incarcerated inguinal hernia, and on whom the finding of a hemangioma of the cheek was somewhat incidental.

I think that most of you can see that this

child has a hemangiomatous lesion approximately 4 x 2.5 cm. in size on the right cheek, going up into the lower lid on the right.

We will use these two cases as a starting point for our discussion. I might remark that when I told Dr. Pettit that we were going to discuss hemangiomas today, he said, "Surely you don't consider them as pre-malignant lesions." I replied, "Well, no; not until they've been given x-ray treatment."

Doctor Harrold, I wonder if you would start the discussion with your thoughts on the treatment of hemangiomas, both the smaller ones and the larger problems, such as our first patient.

Dr. Harrold: Well I would begin by saying that Memorial Hospital started out initially as a hospital for radium and x-ray therapy, and everything was treated by radium and x-ray—no exceptions—and there was no exception about hemangiomas. They were treated too. They were treated by radium plaques, radon seeds, radium needles, low voltage unfiltered, low voltage filtered, 250 KV, and so on. However, I think very few of them had 250 KV. But this type of treatment often resulted, especially in children, in damage to the bone



FIGURE 2

structure of the face. Now right away it is only fair to say that some radiologists will say, "Oh, yes, but that was 20 or 30 years ago; we know what we are doing now." Well, that may be true, but there is absolutely no question about the fact that irradiation, no matter how it is delivered, is not selective in cases like this, and there is going to be damage to normal tissue as well as to the hemangioma tissues. Now, there is an article in *The Journal of the American Medical Association* this week by some very well-known dermatologists in New York who are still saying that the radium plaque is the treatment for it—gamma radiation. It is a curious thing, but this is the first time that I have noticed that this particular dermatologist is now putting into his papers some items on surgical treatment. And so I think that if Herman Talmadge can move Stone Mountain, maybe we can do something about treating hemangiomas in ways other than radiation. I see Harold Pettit over here is champing at the bit. I can afford to say these things, because Harold is a good friend of mine. I was just reminiscing a minute ago and at the risk of prolonging it a minute, I would just say that this is a pretty good story. Harold was a resident in radiation when I was at Roosevelt Hospital on the Surgical Service in 1940, and one day we had a colored lady who was brought in for routine x-rays or something, and she had a metallic object in her stomach. Harold Pettit saw it and said, "This lady has twenty-five cents in her stomach; she has two dimes and a nickel." And so we said, "Well, she's neurotic and she knows she has something in there, let's take it out." So we put her to sleep and opened the stomach and we got out two dimes. We called Harold, he came up, and we ribbed him: "All right, now we've got this stomach open and you said there is a quarter in there, and we've only got twenty cents." He said, "Well, you tightwad, look up there in the fundus, you'll find the nickel." And there it was.

But to get back to the specific—Dr. Hawk has presented a very pertinent problem because he has presented the very worst kind of hemangioma that you can get in a child. Now, many of the hemangiomas that you get and some of the lymphangiomas too, can be

treated and treated very adequately, with CO₂ or with sodium morrhuate or some other sclerosing solution. But it is my opinion that a lesion such as this is not going to respond to further sclerosing injections. As a matter of fact, if you compare the patient now with what Dr. Hawk showed initially, the thing looks bigger to me. Now I don't think this is terribly significant, because I think the child's bone, clinically, still looks as if it is normal. I think that you could give a lot of treatment to the hemangioma element, but I think that you will be faced sooner or later with doing surgery on this.

I have another good friend who practices in Albany, New York, who maintains that this type of lesions is no problem at all. He says that this whole thing is fed by one vessel, and he recently made some of his old friends just a little bit sore at him. We had a case very similar to this that I had treated by injection. As a matter of fact, I injected it just once and the child immediately had a reaction to the injection. The lesion extended down into the neck just as this one does (and very often they also go down into the thorax), and what happened in this particular case was that the child had respiratory obstruction and a tracheotomy had to be done. The child, being only about six months of age, ended up staying in the hospital for about six months, needing constant nursing care for the tracheotomy, since we were unable to get the tube out. Now as for my friend who says this is all fed by one vessel, the thing that got us a little bit sore at him was that when he saw the case he said, "What's the matter Charlie, have you fellows lost your nerve? All you've got to do is ligate the posterior branch of the posterior auricular artery and this will all collapse." Well, that is obviously silly to anyone who has ever operated on these things. You've got to be extremely careful, you have to have control of the whole thing, and it is not fed by just one vessel; in my experience, there are many. But if you can stay out of it and get a complete excision, I think this type of thing can be handled. But personally, I would be in favor of delaying that surgery until the child's trachea is a little larger and you can be certain that you can get the tracheotomy tube

out.

Dr. Hawk: Thank you very much, Dr. Harrold. I am very glad to learn that at least at one time in the past, one could have an exploratory gastrotomy for twenty-five cents! That is a little bit low, even for Charleston.

I think we ought to let Dr. Pettit speak on radiation therapy at this time.

Dr. Pettit: These two examples you have seen today, Dr. Harrold is welcome to. I don't think radiation therapy has anything to offer them. If you did try to treat them, you would have to give them very large doses and you would damage underlying structures. You would be doing the child more harm than good. Some smaller hemangiomas can be treated very nicely with x-ray, not with unfiltered radiation, though. If the hemangioma is so small and so thin that it doesn't need a filtered beam, it doesn't need treatment. The patients that we see with hemangiomas we feel are lucky because we don't give them any treatment at all in most cases. We spend about half an hour talking to parents and convincing them that the child will probably be all right. But we do ask them to keep coming and let us watch the child, and if the hemangioma begins heading for a spot where it would be unwieldy or cause some damage, or if it looks as though it is going to grow so fast that it might get out of bounds, then we will give it some treatment. We try to hold that down to 200 or 300 r. and make just one treatment. You have to be patient with these lesions, and most times, you don't know whether radiation treatment is what helps, or whether there is an obliterative arteritis going on anyway. But the least treatment is the best treatment, in the usual case of hemangioma. The strawberry hemangioma is the most common, and is easy to handle. Obviously, these two cases are not in that category, though.

Dr. Scarborough: I wonder if Dr. Murphy would agree with our pediatricians. They say that hemangiomas all get well anyhow, in Atlanta. I wonder if she would like to talk about that.

Dr. Hawk: Dr. Murphy, do you want to answer that?

Dr. Murphy: We certainly hope that they do. Usually I send a patient like this to Dr.

Harrold and his colleagues and ask for their opinion. If I agree, then I go along with the treatment. I just saw an infant of this age who had a large hemangioma of the leg. It was actually bigger than the baby. This child also presented an additional complication that we sometimes see with very large hemangiomas, namely, a bleeding tendency. It was recommended (not by Dr. Harrold but by some other surgeons), that this baby have an amputation of the leg, because of his hemorrhagic tendency. We did not agree with this, and we watched the baby for about three years. The hemangioma began to subside after several months, and now it has practically disappeared. I think we always hope that they will go away, but in the older child I doubt if this is going to happen.

Dr. Hawk: Would any other members of the panel like to speak on the subject?

Dr. Scarborough: Dr. Pettit said something that I think is important. If you can get these things just to begin sclerosing some way or another, they seem to carry the process on. I have been through this treatment of hemangiomas and in spite of what you have said about radiation, I think in a desperate situation such as we have presented in this first little colored child, there is a place for very weak radon seeds. I know Dr. Harrold won't agree with this at all. But I have used them and I have seen lesions change. I certainly agree with his watching the thing and not doing anything to it now. I agree with him in that it is a combined hemangioma and lymphangioma and he knows and I know, and I think we ought to say this, that babies with lymphangiomas may die when you operate on them, for some curious reason other than just interference with their breathing. I mean, you can have a good tracheotomy, and yet for some reason or other they die. You want to avoid operating on lymphangiomas and cystic hygromas if you can keep from it because the mortality rate is so high. So I believe if I had watched this enough and treated the mother as you said, and that is who really has to be treated, I might use gold (radon) seeds—a few gold seeds at the periphery of this thing in the order of 2/10 of a millicurie or something like that in this patient. I have

not seen fistulae develop. The vascular people seem to be scared to death about the development of A-V fistulae in them, and it is a rare sort of thing. I can remember one that had one in the cheek—a sort of cirroid aneurysm. But I have only seen one child—a lawyer's child—who had that complication.

Dr. Hawk: I don't want to leave an interesting subject hanging in the air but I think it has been covered very fully and we will pass on to the next patient, a 68 year old white man who was seen initially in our clinic on June 27, 1955 with a history of skin lesions since 1926. He always had a very sensitive skin with poor tolerance to sunlight. He had had various forms of treatment with very satisfactory control of most of his lesions over that period. Three months before his initial visit he noted bleeding from the left side of the skin of his nose and had a progressively increasing ulcerative lesion. The condition of his face is shown in the next slide. You see

There was likewise a deep ulcer over the left side of his nose, 2.2 cm. in diameter. He also had an 8 mm. lesion of the right cheek, crusting of the left cheek, and a small lesion of the right nasal ala. X-rays showed that there was some destruction of the bone underlying the lesion of his nose. On July 26, 1955, he had excision of the lesion of his nose, including cartilage and bone, and extending full thickness into the nasal passage. He also had excision of the lesions of the cheek and of the right nasal ala. The pathologic diagnoses were: Basal cell carcinoma of the upper nose; keratosis senilis of the right cheek; epidermoid carcinoma of the left cheek and right nasal ala. This man did not have any good local tissue, that is, from his forehead, or his cheek or anywhere—even his neck—to move up for plastic reconstruction, so thus far he has had simply the use of a plastic prosthesis. We have watched him, and have advised him to keep his face greased. You can see his condition at present.

His appearance is demonstrated in Figure 3, with and without his prosthesis.

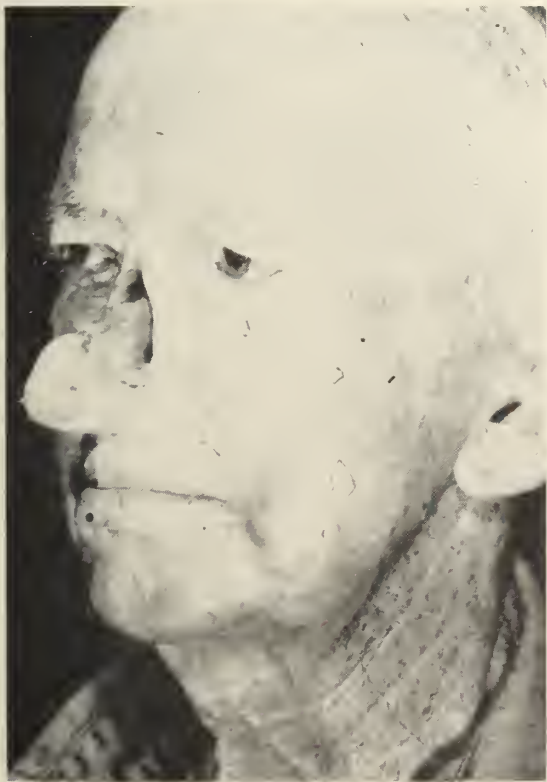


FIGURE 3

that there was considerable scarring and atrophy of his skin and some areas of crusting.



FIGURE 4

I think this presents a very common problem, particularly in the South, where there is a good deal of exposure to sunlight. You can see that he has a prosthesis which he can take off, if you like. I might say that this prosthesis was made in our own department, connected with the Division of Plastic Surgery.

This case will serve as a starting point for the discussion of premalignant and malignant skin lesions which we see very commonly in this locality. I think we should get a basis for discussion by asking Dr. Cuttino to give us a brief exposition of the pathologic changes which one is likely to see in these patients with skin lesions which progress from what might be called keratotic lesions on to and through carcinoma. Dr. Cuttino, would you like to accept that challenge?

Dr. Cuttino: I don't know exactly what you would have me discuss. The field of epitheliomata and dermal appendage tumors is too extensive to summarize here. If I interpret your question correctly, you restrict our attention to the gradations between a senile keratosis and uncontested squamous cell carcinoma, and what criteria cause us to render a diagnosis of carcinoma.

If one accepts the dictum that a lesion is considered precancerous when 20% of them progress into malignancy, then senile keratosis qualifies. There are varying stages of epithelial changes. The minimal changes qualifying a lesion as senile keratosis are pronounced hyperkeratosis, wavy, thickened and disordered rete pegs with some atypicalities, and lymphocytic infiltration into the corium.

Other lesions having these characteristics show greater waviness of epithelium, greater cytologic atypicalities, more mitotic figures with variation of size, shape, and staining characteristics. These changes qualify them as Bowenoid.

Still greater changes and occurrence of invasive qualities of epithelial columns are to be considered carcinoma.

Where is the dividing line? Further, when you remove one lesion with a definite histologic picture, are we justified in assuming that other lesions have the same picture or that subsequent alterations can be associated? Here a philosophic view must be invoked.

Granting that the assumption is correct that these lesions are related and are gradations of the same lesion, the point of general interest is when should they be regarded as malignant?

For my own view the essential criterion is invasiveness or potentiality for metastasis. If one can see feathering of the columns of epithelium with squamous maturation of epithelial cells in juxtaposition to the corium and loss of the protein condensation called the basement membrane, one might assume that the lesion is potentially invasive, since the cells may grow into lymphatic spaces and small blood vessels and away it goes.

Dr. Hawk: I think that all members of the panel have had some experience with treatment of this type of lesion. I wonder which member of the panel would like to open the discussion on it?

Dr. Miller: Anatomically we are divided at Memorial—we treat the lesions below the clavicles and Dr. Harrold treats them above the clavicles, so therefore, he sees more of these problems than we do. We see the types that occur in the arsenical keratoses and those due to contact toxins, but this solar type, I think, is more down Dr. Harrold's alley. I would like to hear how he would manage this fellow. I don't see much to do other than to skin his face and graft him.

Dr. Harrold: I might say that unless they all wear gloves in New York, some of them do get these things on the hands, too. They don't see the sun enough up there to get it on the face. Well, the problem is essentially that of a man with multiple basal cell lesions and some others which are epidermoid, a man of 68 years and who is a nice old person and is going to be in the sun some more—and can't help it; you can't stay in a dark room all your life. Now, the question number one, as you put it, you want to know when and if I would consider any reconstruction of this man? The answer to that is, I think, very easy: No, I would not, because I think that this man's cancer is never going to be controlled. I don't want to be pessimistic, but I think you've just got to face it. I think this is a situation in which it is not just treatment of the cancer—it is treating this man and I would do just as

you are doing, keep him under close observation, and when one turns up I would take it out. It is very close already to his left orbit and it is just a question of holding things off and hoping that you can put off surgery until maybe he gets a heat stroke or something like that. I'll just say one other thing—that once you've got basal cell cancer that has invaded the nasal cavity and has gone into the mucosa it becomes what so many of my associates call "cancer on the march." I would under no circumstances be in favor of any plastic forehead flap or anything of that nature that would close this area and keep it from your vision. I think the ideal treatment is what you have done plus the plastic prosthesis. I think this is a made-to-order case.

Dr. Hawk: Dr. Pettit, would you like to speak of the radiation therapy of these skin lesions, not particularly in this case but in the early skin lesions of this type?

Dr. Pettit: You would go to any length to find something that is better treated by surgery. Giving radiation therapy to a skin like this is letting yourself in for an awful lot of trouble; you will clear up one area and the thing will look fine for six months, a year or so, and then you will find that you are treating another area bordering it or overlapping it, and pretty soon you overlap fields that have had heavy radiation therapy, and then you have to go looking for somebody to take care of the slough. I am always worried too about inducing carcinomatous changes in a skin that is already prone to develop carcinoma—at the margins of the treated areas where the low doses of x-ray are acting just as the sun's rays have. That is one of the reasons why we invariably end up with a carcinoma that can not be adequately treated without overlapping a previously irradiated area.

Dr. Hawk: Dr. Scarborough, would you like to say anything in regard to excisional surgical treatment versus electrocoagulation, etc.

Dr. Scarborough: I agree essentially with Dr. Harrold. I think, given a patient with a skin of this type, I am perfectly willing to let him go along with a few basal cells on the skin of his face, and the very, very small ones I think you could coagulate and you could kill them if it is done thoroughly and com-

pletely. I would certainly try to avoid irradiation whenever I possibly could in this fellow's situation, and treat it mostly with a wide-brimmed hat. Now this man, though, this particular individual, has complications, that is, he has bone involvement and cartilage involvement and mucous membrane involvement, I suppose, through and through. I don't know any other way after he got that; he had to have this procedure. But I think we can make a mistake over-operating on these people. If he has a big basal cell cancer on the skin of his nose and even with some small ones within 2 or 3 cm. of it, we have taken them out and taken just a freehanded cut graft and put over the area, and I think that is the simplest thing one can do. I agree with Dr. Harrold that this one should not be closed except that I would ask Dr. Harrold: If this man insisted on having something more than that very excellent prosthesis, how long would you wait before you would let him have it? Or maybe if I ask that another way—would you be willing to let him try to have a flap—and that can be done in this man pretty satisfactorily, I think—after he had gone for a year without evidence of further disease?

Dr. Harrold: I can remember trying to trap one of my friends with a situation like that, and his reply was, "Yes, but every year I would reconsider this."

Dr. Scarborough: I wasn't trying to trap you—I just mean that we do the same thing. But after the patient has gone a year, if he has no evidence of disease—and we give him at least a year, because at least 75 per cent of these basal cells will recur in six months but another 25 per cent may even take more than a year, so we say if they have gone a year—then we might go ahead and try it.

Dr. Harrold: In all seriousness, I think Dr. Scarborough has a point. If this were a man, say thirty years old, I would treat this situation with a lot more thought as to how and when I would try to have some reconstruction done. But on the other hand, as I understand, this one that you took out invading the bone was epidermoid, wasn't it?

Dr. Hawk: No, the one that was invading the bone was basal cell.

Dr. Harrold: Well, it doesn't really matter.

I mean, I would still be extremely reluctant in a situation of this type with basal cell cancer invading bone, and with the type of excision that has been done, I would be extremely reluctant to advise a reconstruction after a year. I might after eighteen months, but I think this patient has been treated just right, for him. But if in a younger man you had this type of situation I would be extremely wary about having the disease under control. After all, I think you feel that way too.

Dr. Hawk: Are there any questions from the floor anyone would like to ask on this very difficult subject? If not, we will leave this problem and go on to a little more complicated one. The next patient, a 62 year old Negro woman, was seen in the Cancer Clinic just three days ago with a breast mass of five or six months' duration. She gave a history of feeling "shooting pains" in the breast for three or four weeks. There was no history of breast trauma or previous breast disease. She had noted herself the presence of axillary nodes for about two weeks. She was found to have a thyroid mass, and on direct questioning, she admitted that she had had it for many years—she didn't know exactly how long. We will bring her in. We have spoken to her and I think she will not object to our visualizing this rather advanced carcinoma of the breast. Also, we will be able to see the thyroid nodule, which is just to the right of the midline and is about 3 cm. in diameter.

I think you can easily see that she has advanced carcinoma of the right breast, chiefly underneath the right nipple, with skin fixation and some fixation to the areola. There is a chain of lymph nodes extending into the right axilla, with the largest node 2 cm. in diameter. The thyroid nodule is freely movable. She has no supraclavicular or cervical adenopathy and no nodes in the opposite axilla. There are no evidences of distant metastases; aspiration biopsy of the breast mass showed carcinoma.

We actually initially intended to present this patient chiefly from the standpoint of a solitary thyroid nodule which I think is a very difficult problem and one which can lead to all sorts of discussion, but we will open discussion first with a brief consideration of the treatment of her breast lesion. Dr. Urban?

Dr. Urban: As far as the local clinical findings are concerned, I believe it is operable. I assume all the x-ray surveys, chemistries, etc., are all negative.

Dr. Hawk: They have not been completed, but I think we will just work on that assumption.

Dr. Urban: Well, if she had only the breast lesion, I think we would probably treat her with a straight radical mastectomy. Her lesion is not fixed to the muscle; it is not freely movable, but it is movable on the chest wall. The axillary nodes are freely movable, even though they are large. I personally would do a straight radical on this patient and probably supplement with x-ray therapy. About the thyroid situation—I think it would be interesting to do an aspiration biopsy on that and see what I found. If it were benign, I would pay no attention to it, treat the breast and then worry later about the thyroid. It is conceivable but it is very unlikely that the thyroid nodule has anything to do with the breast lesion, especially if she really has had it for a long time. Her opposite axilla is free, and I couldn't feel anything in the base of the neck. She has some ulceration there on the breast, but I wouldn't consider that a contra-indication.

Doctor Hawk: I think there are many clinics—we could name one or two—in which this would be classified as an inoperable lesion on the basis of the local extent of the disease and the degree of axillary involvement. However, I think most of us can agree with what you have mentioned. Doctor Parker, would you like to make a comment? We haven't heard from you this afternoon.

Dr. Parker: Of course, you haven't presented the problem in which I am most interested, but I would like to make a comment here. Doctor Miller's statement about the clavicle as the dividing line reminds me of the story about the Naval officer who had the caduceus on his uniform and all the other insignia. He was getting sick and tired of being questioned about his brass buttons and blue coat. So, one day a woman asked him what he was in the Navy, and he said he was a commander. She said, "Well, what sort of work do you do?" and he said he was a doctor.

She said, "Well what kind of a doetor are you?" and he said he was a surgeon. She said, "Well, what kind of a surgeon are you?" and he said, "I am just a naval surgeon." She said, "My, how you doetors do speeialize!!"

I agree with Dr. Urban's saying that she unquestionably has an operable carcinoma. He made a most impressive statement this morning, to me, and that was in regard to the question of giving the patient the benefit of the doubt. I think unquestionably this woman should have radical mastectomy as the primary treatment for the carcinoma of the breast, and I agree with aspiration biopsy of the thyroid. If it was benign, I would certainly wait and see the outcome on the breast before considering further treatment, in view of the apparently long presenee of the thyroid nodule.

Dr. Hawk: Well, it appears that most of the panel are agrced that this woman should have a radical mastectomy. Is there anyone who disagrees with that? Then, we will proceed. I think we could get into quite a discussion as to whether she should have postoperative x-ray therapy. Dr. Urban, would you like to give your philosophy in regard to postoperative x-ray therapy?

Dr. Urban: I think that is a good term, philosophy, because it is all individual, really. We really don't know enough about it to resort to x-ray therapy following surgery for breast cancer. If this patient were, say 45 or 50 years old, we probably would do an internal mammary resection on her as well. At her present age, with rather bulky disease, I think I would settle for a straight radical, followed by x-ray therapy, if we found positive nodes in the axilla, which I am quite sure we will. I personally don't treat the chest wall at all, as a rule. In this patient, with the lesion rather adherent to the underlying soft parts, even though it is fairly movable on the bone, I believe one would be justified in treatment of the chest wall underlying the lesion directly. And I would treat the axillary and internal mammary areas with a sort of hockey stick field, covering the apex of the axilla, the base of the neck, and the internal mammary area. I would treat it anteriorly as well as posteriorly across the shoulder, and use about 3000 r at

each port. That is what we would use as a routine and with that routine and radical mastectomy, I think her local recurrence would rate with the internal mammary resection, which has been under 3%. I don't think as a rule you have to treat the chest wall itself, and we aim our x-ray therapy toward the node-bearing areas primarily.

Dr. Hawk: Doctor Pettit, would you like to speak on postoperative x-ray therapy before we get off on the thyroid?

Dr. Pettit: Around here, you can't treat the chest wall any more after a radical mastectomy. You have a little tiny pieee of parehment between you and the lung. And so we have quit trying to treat the chest wall. We use that hockey stiek method—first time I have heard that term—but that is exactly what we do. We treat the axilla, supraclavieular region over to the midline and then treat the mediastinal area. We have been treating both internal mammary chains. Is that what you advocate, Dr. Urban?

Dr. Urban: Actually, our port usually goes from one costochondral junction on the operated side to the opposite side of the sternum. Sometimes it will cover the other side. There is very little information about involvement of the opposite chain in early cases. Wangenstein used to take both chains out when he did a super-radical, and he didn't find a single metastasis on the other side in his first 50 cases, so I think that as a practical measure the cross spread doesn't often occur. If you were to investigate autopsy material you would probably find a lot there, but you would find it everywhere else, and it doesn't mean very much as far as definitive treatment in the early stages. But I don't think you would do any harm, and it might benefit to include it, I would not object to it, certainly.

(Radical mastectomy was performed on this patient on November 11, 1957. Lymph node metastases were demonstrated at all levels of the axilla. She was given postoperative x-ray therapy from December 3, 1957 to December 31, 1957. No treatment has been given to the thyroid. She was doing well when seen for follow-up examination on January 31, 1958).

Dr. Hawk: We have here another thyroid

nodule which poses a problem. This 56 year old white woman, Para VII, was seen initially on August 8, primarily in regard to a lesion of the right cheek which was excised and proved to be an epidermoid carcinoma. She has a 3x4 cm. nodule in the lower pole of the right lobe of the thyroid, which is freely movable. She says it has been present since she was fifteen. She, perhaps rightly, was not interested in having us do anything with her thyroid. She came to us because of the lesion of the skin and she is very happy with the treatment that we carried out.

Dr. Harrold, would you like now to open discussion on thyroid nodules? And I would like you to comment also on thyroid nodules of the younger age group.

Dr. Harrold: How long do you want to take on this?

Dr. Hawk: About five minutes—better, three minutes.

Dr. Harrold: I feel toward a thyroid nodule as someone has said about sin—I'm against it. In regard to the first patient with the cancer of the breast and the thyroid nodule, I don't think that there is much point in going into further discussion about that. I don't think anyone here would be willing to take a strong stand about doing a thyroidectomy on that lady. Her breast cancer is far and above the most important. The thyroid nodule certainly clinically is benign and the worst you could expect, or that I would expect, on the first patient would be a papillary cancer, and at her age of 68, even if she had it, I might not treat it anyway. So I would just reserve it.

Now there was a question brought up about aspiration biopsy. Aspiration biopsy for cancer of the thyroid is by far the least reliable use of aspiration. It is quite difficult and the way we look on aspiration of thyroid cancer is that if we have a positive, all right, but if we have a negative, we don't necessarily believe it. Besides, we have the feeling that if you are going to operate on a thyroid nodule, you are better off to do a lobectomy and have a frozen section. Now the pathologists don't always like that, but we finally have worked out something of a compromise so that we understand their problem, and they understand ours, and it is like the old Negro says,

"We just does the best we can". We think the frozen section is more reliable.

Now, about this second patient, this is still a free country and she is entitled to do whatever she wants to do, but I certainly would put it up to her. The way I would try to analyze this, I'd say, "You do have a lump in your thyroid gland and I don't care how long you've had it, you can have it twenty years as far as I'm concerned, or 30 years, but you've got a lump there, and it wasn't always the size it is now. It must have been smaller at some time. I think you ought to have it removed." She might object a little, and then I'd say, "Well, this is the situation: the risk of doing a thyroid operation on you is probably approaching zero, whereas I feel that there is enough risk in observing you so that it is many, many times the risk of the operation." If you present it in that light—well, I rarely have any trouble when I take that attitude with a lesion of this type. I think if you feel in your own mind that it ought to be done you never have any trouble persuading somebody to have surgery. This, to me, is a very prominent type of a nodule in perhaps a multinodular goiter. There is no question in my mind; I would recommend that it be removed. I think the chances that it would be malignant are certainly not greater than 10%. As a matter of fact I would be surprised if it was malignant. On the other hand, I sometimes feel that I am doing unnecessary surgery, and just about the time that I get that attitude, why I get fooled by a benign-feeling nodule, and it is cancer. Another thing is that, as Dr. Foote, one of the pathologists at our institution has told me, our percentage of positive frozen sections on thyroid cancer is far higher than the number of positive cancers that come from local excisions on the breast, which really makes me feel good. Every time I think that, well, maybe I am overdoing things in doing this type of thyroid work, why Frank Foote comes along and says, "You fellows are not taking out enough." So I am in favor of a hemi-thyroidectomy, and I have no doubt that she will agree to it.

Doctor Hawk: Dr. Scarborough, are you as persuasive in Atlanta as Dr. Harrold is up in New York?

Dr. Scarborough: I agree with Dr. Harrold one hundred per cent. I think a thyroidectomy is such a relatively simple procedure now with good anesthesiologists that there ought to be no hesitation on the part of the surgeon, which, as he said, is the most important thing, nor any on the patient's part. I don't think you'd have any trouble.

Dr. Hawk: Dr. Cuttino over there apparently is getting a little hot about the frozen section.

Dr. Cuttino: We can come back about the frozen section. I want to explain now about the difficulty involved and the possible sources of error in thyroid cancer. I was interested in Dr. Harrold's implying that in some patients he would not have treated a thyroid nodule even if the aspiration biopsy showed papillary cancer, which moves me to comment that it is pretty well known among pathologists that in autopsy series the incidence of carcinoma of the thyroid is very low, whereas in surgical series it is very high. The ratio is some 12 to 1, which raises a considerable question as to how reliable are our criteria for diagnosis of carcinoma of the thyroid in the first place. We find these changes in cells and so on, which we ordinarily accept as malignant, and will make the diagnosis of carcinoma in other tissues; yet in the thyroid it is notoriously difficult. We even went through a period where it was required that we have vascular invasion demonstrated before we were willing to make the diagnosis of carcinoma of the thyroid. Then, we got into the problems about the dirty knife techniques and about microtome knives bringing little fragments into the vessels so even that crutch got very weak. So the point that I was interested to comment on is that I am not so sure that I would be willing to rest easy in making the diagnosis of carcinoma of the thyroid on an aspiration biopsy.

Dr. Hawk: Dr. Harrold, do you want to speak about this modesty on the part of the pathologists?

Dr. Harrold: Well, maybe I don't quite understand Dr. Cuttino; I understand that he agrees that aspiration biopsy in thyroid cancer is a very difficult thing at present. Well, that is the way I feel, and I think that is what I said.

Dr. Cuttino: I am not arguing with you.

Dr. Hawk: Dr. Harrold, would you like to make any other comments on thyroid cancer?

Dr. Harrold: This whole subject of thyroid cancer has been talked and beat around so much that although I always like to talk about it, I am always worried that somebody will say, "My goodness, I hear about it so much, and it is always the same stuff; when are they going to stop?" There is a so-called Crile school; the Crile school has been called cotton-pickers or raisin-pickers out of the cake, or just node-pickers. The others are the neck dissecters. Now, I am a neck dissector. Really, it is an extremely difficult thing to argue with Dr. Crile. You have to have respect for his opinion. I don't know what he has for mine—but he probably has some for my associates. But Dr. Crile agrees that in the treatment of a thyroid nodule the treatment should aim at cancer. For example, you take out a nodule, a small nodule, not because of mechanical reason, but you take it out because you think it might be cancer. Now the best way to handle that is to do a hemi-thyroidectomy, and strangely enough, if you go over some of Dr. Crile's work you will find that he agrees. Now, I think that is the first step—do a hemi-thyroidectomy, not an enucleation of the nodules, because that is when you are going to get in trouble. If you don't get it all out, you split it up, and if that's cancer, why then you've got a problem. First thing is a hemi-thyroidectomy. From that point on there is no agreement whatsoever, and it really becomes chaos. Doctor Crile believes that nodes should be removed, but he believes they should be picked out from around the internal jugular vein and elsewhere. He feels that he can do a better excision of thyroid nodules and the lymph nodes in this "picking" procedure under a limited type of anesthetic than one can in a so-called radical neck dissection. As for me, I can't understand that, and I can't—just cannot—follow it: how the individual picking up of a node here and yonder in the neck is a better procedure than doing a neck dissection. Now, there is even one step further than this. There is Dr. John C. McClintock who goes one step further and does a superior mediastinal dissection. Doctor McClintock has some seventy-

odd cases with an appreciable number that have nodes in the mediastinum. So the whole picture is clouded by the fact that the natural history of thyroid cancer, that is, the great majority of cases which are low-grade thyroid cancer, follow an extremely long course, and a five-year yardstick that is used for squamous cancers, or glandular cancers in other areas, is of absolutely no value. You have to follow cases for twenty years and compare different modes of therapy to be able to give any real, firm statement. So I hope I have covered it. It boils down to the fact that you should do a hemi-thyroidectomy, taking enough normal tissue so that you will at least get out the local disease. Now, from then on, if you believe in taking nodes out, then I think you ought to do a dissection. Other people say no, they'd pick them out. And certainly time is on their side. You can't prove it.

Dr. Hawk: Most fortunately, we don't have a member of one of the other schools to argue with and so we can just leave it at that point with the feeling that there is agreement on this panel that the solitary thyroid nodules and in most cases the multinodular goitres should be removed, and the solitary nodules by hemi-thyroidectomy.

(The second thyroid patient, E. L., finally agreed to operation. Right hemi-thyroidectomy was performed on January 16, 1958. The pathologic diagnosis was nodular goitre).

I would like to get on to at least one other subject that I think will be of considerable interest. The patient is a 40 year old white man, who was initially seen here in April 1957 in regard to leukoplakia. This had been first discovered while the patient was in the Army in 1945 and he tells of various local treatments. He was seen by Dr. Grant Ward in Baltimore and the leukoplakia was removed with the electrocautery. He had previously been a heavy cigar smoker but following this treatment he was persuaded not to smoke for six years. He then began smoking again, up to ten or twelve cigars per day. He noticed recurrence of leukoplakia in the Fall of 1956. When this began progressing, he ceased smoking again and sought medical attention. At the time I saw him initially he had patches of leukoplakia on the buccal mucosa on each

side with some filmy extension onto the lower gingiva. There were no particularly thickened areas.

I am sorry it is not possible for everyone in the audience to visualize the lesion, but I think this will serve as a starting point for discussion. In the past there has been some discussion of treatment of leukoplakia with various forms of irradiation. I would like Dr. Pettit to begin. He remarked that we weren't going to give him anything good to discuss, so we will let him talk about radiation therapy in leukoplakia also.

Dr. Pettit: I would say it rarely has any place in the treatment of leukoplakia. I have treated leukoplakia where it was continuous with areas of epidermoid carcinoma, and have given the leukoplakia areas the full therapy dose. It would be wise at times, it would be feasible at times, to treat an area of leukoplakia that has undergone malignant change with local x-ray or radium, but you have just as much of a problem there as you have with a "farmer's skin" or "sailor's skin". A few years ago we started to treat some leukoplakias of the lip with beta ray applicators, but I couldn't follow the patients long enough to find out if it was doing any good or not. Invariably, I was using other things also: getting them to stop smoking and using lanolin on the lips. They were improving but they would get disgusted and that would be the last I would see of them. So I never did find out whether the beta radiation was of any use or not.

Dr. Hawk: Is there a smoker in this group who would like to discuss this subject? Is there a smoker on the panel?

Dr. Scarborough: I will tell you what I would do about him. I don't smoke, nobody in our clinic smokes, and I never have told a patient not to smoke, but he has already learned his own lesson. Dr. Ward told him not to smoke, and he quit and he got better, and then he started smoking again and he got worse, and then he quit again and he doesn't smoke now. Right now he hasn't got anything that is even suggestive of cancer in his mouth. And I think if we can get him to keep his mouth clean, I wouldn't be putting any radiation in his mouth; I wouldn't even fulgurate it. I would leave him alone and I would let

him use his good judgment. He ought to have sense enough now not to smoke.

Dr. Hawk: Well, this is the sort of condition where you have a second chance. Of course, there are some other conditions where you don't. Dr. Parker, do you want to talk on this subject?

Dr. Parker: I think the die has been cast by Dr. Scarborough.

Dr. Hawk: Dr. Harrold, do you have anything to add? Would you like to say anything about the general measures to use in leukoplakia?

Dr. Harrold: No. This is such a discouraging kind of a lesion because it is right on the surface where you can see it and feel it and do anything to it and it is almost like the common cold. It seems as though its hard to do anything about leukoplakia. We can prove that leukoplakia goes into cancer, and we have leukoplakia appearing with cancer, and there it is. It is just as if a dermatologist had a skin lesion and all he did was put sulfur on it; all we seem to do is tell them to stop smoking and exercise the usual oral hygienic measures, get the teeth cleaned up and so on. The next thing we do is give them Fleischmann's 20-40 Yeast. And sometimes when they get tired of that or they get so bloated they can't hold it, then we try them on heavy doses of vitamin B. Sometimes that works, sometimes it doesn't. Finally when there is a very red mouth with the leukoplakia we go ahead and give parenteral vitamin B and sometimes we get a good response from that, but the only drawback is we can't keep it up forever. So it is a very discouraging field sometimes, and I think this fellow is very fortunate. I think Dr. Scarborough has described it rightly. There are so many different kinds of leukoplakia I wouldn't know just what the pathologist describes with the multiple terms used by Army museums, but after you have seen a good bit of leukoplakia you can develop a knowledge of the kind that you think is going to give trouble. Now I think this type is not going to give it, certainly not the way it is now—sharply demarcated, almost as if you had drawn a line where the lesion is. This type looks almost as if it had been splashed on there like a little flake of paint, and my experience with that

type of leukoplakia is that it always seems to go away. Of course I haven't been in practice very long, and maybe I am going to be wrong, but there are other kinds that I think are much worse.

Dr. Cuttino: As far as I'm concerned, leukoplakia is a white spot.

Dr. Scarborough: He's the pathologist—he has to have the last word!

Dr. Hawk: We have a few written questions for the panel, and there may be some additional questions from the floor. I would like to start on these. Doctor Parker, do you give routine x-ray therapy after an apparently successful removal of a lung for carcinoma? If not, what are your criteria for x-ray therapy after pneumonectomy?

Dr. Parker: Well, I don't think we follow any absolute set rules on that. I think it depends upon the general condition of the patient, in addition to the cell-type of the carcinoma and whether there are mediastinal metastases. Now if there is residual tumor in the thorax and no distant metastases elsewhere, or if there are many nodes removed which are found to be involved by carcinoma and there are no distant metastases elsewhere, we definitely believe in postoperative x-ray therapy. But if the patient, on the other extreme, is one in whom it has been possible to remove all the carcinoma, including a mediastinal lymphadenectomy, with no remaining tumor and no metastases histologically, we would not give x-ray therapy.

Dr. Hawk: Dr. Miller, do you at the present time advise right hepatic lobectomy for carcinoma of the gallbladder? Do you feel that is the treatment for carcinoma of the gall bladder?

Dr. Miller: We would still feel that, but I am afraid we will eventually have to abandon the idea. We haven't had enough cases yet, but I think that from the trend and the location of our metastases, the metastases are going to defeat us, not so much the problem of the invasion by contiguity of the carcinoma, but the fact that the disease is very early in the retroduodenal nodes and the paracardiac nodes.

Dr. Hawk: Dr. Urban, would you discuss the indications for prophylactic castration in

the treatment of carcinoma of the breast?

Dr. Urban: Well, first of all, prophylactic castration in carcinoma of the breast by definition is castration of a patient who has had definitive treatment for cancer of the breast and has no clinical evidence of the disease at the time you castrate her. Therapeutic castration is castration made when you are sure that the patient has residual disease. Now actually, there would be no point in giving prophylactic castration if the patient were really free of disease. It is merely that you can't prove whether there is any residual disease. The only point in giving prophylactic castration is this: You find a patient in whom you assume that because of the extensive nodal disease or widely extended disease locally, that even though you can't prove she has disease by clinical examination or laboratory work or x-rays, she in all likelihood does have further extension of this disease in the nodes or possibly in the bone marrow, but it is subclinical at the time you are treating her. And you do a prophylactic castration in an effort to delay the appearance of these subclinical metastases as clinical evidence of disease: bones lesions, lung metastases, node involvement, etc. Actually the only evidence that I have ever heard that was any good to show that it is effective to a certain extent was some collected material which showed a thousand cases with no castration and a thousand cases with castration following radical mastectomy. I don't know how, but these were totaled up somehow, and the first year and second year salvage rate was 10% greater in the group that had been castrated, but the

three, four, five year salvage rate was the same. And it would indicate to me that what the castration does is to delay the progress of the disease a year or two, and then nothing more happens. And in my own mind and own philosophy on it, I am not sure whether it is better to give prophylactic castration or whether it might be better to wait for some early signs of recurrent disease to appear and then castrate the patient. You can argue rationally that possibly if you wait for metastases you would slow down the disease a little longer and get a longer salvage rate. I don't know, frankly. What I would do in practice is that if I had a patient, say, 32 or 35 years old with all nodes involved in the axilla or up to Level I in the internal mammary chain, I would radiate the dickens out of the node areas and operate on the internal chain, and probably recommend surgical castration. On the other hand, if she had two or three nodes low in the axilla or one in the middle of the internal mammary area and we took it out widely and thought there was little evidence of disease having gone any further, we would not recommend prophylactic castration. We would sit tight and just let it go at that. Prophylactic castration will not prevent appearance of the disease; it will slow it down so you can look for it

Dr. Hawk: The corollary to that is another question in regard to when do you do adrenalectomy when there are advanced metastases, and that of course gets into the entire problem of the hormonal approach to breast cancer, which I believe is going to be beyond our scope this afternoon.



OBSERVATIONS ON CARCINOMA OF THE LUNG

EDWARD F. PARKER, M. D.
Charleston, S. C.

Dr. Eargle, members of the Academy, and guests. This morning we thought it would be of interest to review some of the major features in connection with carcinoma of the lung. It is always of tremendous interest that it was only 25 years ago that Dr. Evarts Graham of St. Louis, Professor of Surgery at Washington University, performed the first successful one-stage pneumonectomy for carcinoma. All of that is necessary, because it wasn't the first pneumonectomy, it wasn't the first for carcinoma, and it wasn't the first one-stage pneumonectomy. But it was the first successful one-stage pneumonectomy for carcinoma—25 years ago, an amazingly short length of time in the history of medicine. It is also a tragic paradox that Dr. Graham died just last year of carcinoma of the lung.

Carcinoma of the lung is a very common disease. It is more common than carcinoma of the stomach. It has been more common than carcinoma of the stomach since at least 1940. The last time I went over the records in our hospitals and the autopsy records in the Department of Pathology, the cases of carcinoma of the lung outnumbered those of carcinoma of the stomach. This is important, because it involves the question of the index of suspicion in diagnosis. If a patient complains of indigestion of any type for the first time in adult life, there is no one of us who wouldn't think of carcinoma of the stomach or intestinal tract and who wouldn't carry out every indicated examination in order to determine its presence or absence. But if another patient in the carcinoma age voices some pulmonary or chest complaint, we are not as apt to think of carcinoma of the lung as a possibility as we should be. Yet it is a more frequent disease than carcinoma of the stomach.

The incidence is greatest in middle-age and

beyond, around the fifties and sixties with a decreasing incidence above and below that. Our youngest patient was aged 11 years. We find that carcinoma of the lung is about equally divided between the non-private and private patients. That is a contrast to some other carcinomata, in particular carcinoma of the esophagus with an incidence of 94 per cent in non-private patients. It is unusual to see a private patient in this locale with carcinoma of the esophagus. It is common with the lung. The incidence in the white and colored seems to be roughly the same, maybe a little bit higher in the white.

The etiology of carcinoma of the lung we do not know. The question of whether or not smoking is an etiological factor is of great interest. I do not know the answer. I do know that we see people who have carcinoma of the lung who have never had tobacco touch their lips in their lives, and it would be nice to know what causes carcinoma of the lung in these as well as in those who happen to be tobacco smokers.

The difficulty with carcinoma of the lung from the standpoint of symptoms is the fact that there are no characteristic symptoms whatsoever. In fact, there may be no symptoms whatever. The presence or absence of symptoms depends on many factors. It is logical that it would depend upon the size of the tumor, the location of the tumor, and its rate of growth. If the tumor is in the periphery of the lung and does not involve a major bronchus, often the tumor must become rather large before it gives rise to any significant percentage impairment of pulmonary function. On the other hand, a tumor may not be nearly as large in order to obstruct a bronchus if it is located centrally. Here it may give rise to a cough, perhaps sputum, perhaps hemoptysis, and other symptoms which should arouse one's suspicion more readily. Oftentimes the

symptoms associated with carcinoma of the lung are not those of carcinoma *per se* but rather the symptoms associated with partial or complete bronchial obstruction. There may be pneumonitis of any degree, or bronchiectasis. We have to be exceedingly cautious in a patient with bronchiectasis to make certain that the bronchiectasis is a primary disease and not just secondary to a bronchial obstruction that we can not very readily see by indirect methods. There may be a lung abscess secondary to a bronchial obstruction which is neoplastic. It may be exceedingly difficult to determine the presence of the neoplasm by the indirect methods of examination that we have. The majority of people with carcinoma of the lung who have symptoms—I stress that, because again not all have symptoms by any means—have symptoms for an average of about six months before the diagnosis is established.

There are no physical signs that are characteristic of carcinoma of the lung—absolutely none. There may be signs of atelectasis or poor air-exchange; there may be signs of infection, but there are none that are characteristic of carcinoma itself.

As with other internal carcinomata, the most important feature in diagnosis is suspicion. It is impossible to make a diagnosis if we don't think of the possibility. Beyond that, the history is always a *sine qua non*, particularly in those patients who have symptoms of pulmonary disease but who have perfectly normal x-ray films of the chest. The physical examination is important but it is not as important as the history, I believe, with proper analysis of the history, with one exception. That is in the case of differences in the air exchange in the two lungs, or in any given lobes. If there is a difference in the air exchange, regardless of any other physical signs, that is very strong evidence that there may be a partial or complete bronchial obstruction. Beyond the history and physical examination, certainly the examination of the sputum, if any is available, is most important. In patients with pulmonary diseases with sputum, if we examine the sputum often enough and in the proper ways, we can find the cause most of the time. That applies to tuberculosis, fungus diseases, non-

tuberculous pyogenic diseases, and carcinoma. We are extremely fortunate here to have a group of pathologists who are extremely capable and interested in the cytological examination of the sputum. The result in our department here in patients raising sputum has been about 80 per cent positive diagnosis in those subsequently proven to have carcinoma. That is as good or better than in almost any other institution. As one goes around to different meetings and sees one's friends and talks about common problems, they are amazed to hear me make that statement concerning the cytological examination of the sputum in our Department of Pathology.

Next is bronchoscopy. Bronchoscopy has to be done, but not always for diagnosis because fortunately we are able to get it by examination of the sputum in a high percentage of cases. When not needed for diagnosis, it is needed to determine the extent of the disease, and whether or not the lesion may be operable or inoperable. Because there are as many carcinomata of the lung occurring peripherally as centrally, because of the size of the bronchoscope and the limit to which it may be advanced, bronchoscopy is diagnostic in only about 40 or 45 per cent of the cases. Still, bronchoscopy has to be done, if not for diagnosis alone, to determine the extent or the possible extent of the disease.

Bronchography we use occasionally, but it gives an anatomical diagnosis, not an etiological, and we want an etiological, obviously, most of the time.

Biopsy of the lung would come next. There are different ways of doing biopsy of the lung. If the lesion possibly is carcinoma and is resectable, then the biopsy of the lung can be done as a major thoracotomy. If the lesion is definitely inoperable, we believe in various lesser types of thoracotomy, down to simple needle biopsy of the lung, or the use of short intercostal incisions. We do not use biopsy of the lung as a method of diagnosis of pulmonary disease as often as we should. A strictly sound principle, we use biopsy everywhere else, and we should use it more often in the lung.

In addition to the above, there are methods for the determination of the presence of pos-

sible metastases, such as biopsy of a supraclavicular lymph node. Examination of any pleural fluid obviously is important. Often-times biopsy of a rib, which may show an abnormality on the x-ray films, is indicated. Lastly, exploratory thoracotomy may be needed.

Since most of the people whom we see with carcinoma of the lung come to us for one or two reasons, that is, symptoms, or an abnormal x-ray film, we find it convenient from a clinical standpoint to divide patients with carcinoma of the lung into four groups: The first and easiest to diagnose are those who have symptoms and an abnormal roentgenogram. Second, there are those who have symptoms and a normal x-ray film. Third, there are those who have no symptoms whatever, and an abnormal x-ray film. And there are those who have no symptoms and a normal x-ray film. The last may have proven carcinoma. We can show a few examples in each group.

In a large lesion like this (slide), the diagnosis is easy. The patient had practically no symptoms at all. The lesion is peripheral. He had only weakness. The lesion was removed. He died a year later, not of carcinoma, but of cardiac failure. With the massive lesion as illustrated, the diagnosis is easy.

Next slide. This is another example of a large rounded shadow in the left lower lobe, fairly well circumscribed; that lesion is carcinoma, of course, unless proven otherwise.

Next slide. There is that tumor after removal. I am sorry to say he died about a year later of metastases. Next slide, please.

This is an example of a patient who had symptoms plus this abnormal x-ray picture. As one can see, there is abnormal obscuration of the upper half of the left lung field. This was taken in January 1947. He had been sick since May 1946. I used to remember well the list of diagnoses that he had had made, prior to establishing the diagnosis of carcinoma. They were numerous, including typhus fever and syphilis of the lung, but he had primarily a cough, malaise, weakness, and loss of weight. He had been seen 2 months before this in consultation and bronchoscopy suggested and advised, but amazingly enough, this was only 10 years ago, bronchoscopy was

not accepted and various treatments were continued to no avail. When bronchoscopy was done two months later, there was an obvious carcinoma in the left upper lobe bronchus, and it is safe to say that the diagnosis could have been established two months before.

Next slide. Pneumonectomy was advised and performed. This is a photograph of the lung with squamous cell carcinoma throughout the hilar region. That was done in January 1947—this is 1957—this patient is still alive and free of carcinoma and is our longest living patient today. That type of tumor is fairly easy to diagnose, and I am sure today the diagnosis would have been made many months sooner than it was at that time, because the patient was seeking medical advice right from the onset of symptoms which occurred seven to eight months before the diagnosis was established.

Next slide, please. Now this was the film of the chest following pneumonectomy. We had another x-ray examination just a month ago. I am sorry I do not have a lantern slide of the last, but it looks exactly like that one. Next slide, please.

This patient was a white man about 70 years of age who had a cough and hoarseness due to paralysis of the left vocal cord. The x-ray shows a large shadow which of course is carcinoma until proven otherwise. Bronchoscopy was performed. There was no intraluminal tumor, but there was marked distortion of the bronchus as by tumor without. He was considered to be inoperable and he died of carcinoma a couple of months later. Next slide, please.

Here is the x-ray film of the chest of the same patient 4 months sooner. He had a cough and no other trouble. This is a normal x-ray film of the chest. At that time bronchoscopy was performed and it showed only slight distortion of the main bronchus but enough to be consistent with the possibility of neoplasm outside of that bronchus. There was indirect evidence of carcinoma. So this man represents in June 1946 when first seen one with symptoms of carcinoma but with a normal x-ray picture of the chest. Without the bronchoscopic evidence, obviously one wouldn't know upon which side to operate. But with the

bronchoscopic evidence of distortion of the left main bronchus; we feel today that operation certainly would have been justified and indicated at that time. Next slide.

This is another example of the same thing. This is the abnormal chest film of a lady with symptoms. This lady was 57 years of age; for the first time in her life at age 56 she developed a cough and after some months she went to her physician, who suspected carcinoma among other things, and had an x-ray examination and it was perfectly normal. It was considered that there was nothing to be concerned about. Shortly before this film was made, the cough having persisted, she developed a pain in her chest, dyspnea and a pleural effusion. The pleural effusion showed the presence of carcinoma cells. She was inoperable right from the start, with paralysis of diaphragm and bloody fluid. Next slide, please.

Now here is the same lady just about six weeks before, with a normal roentgenogram of the chest. I have shown this slide to many radiologists and they tell me that this is normal. This was just six weeks before she had the obvious carcinoma. This is an example of a patient with symptoms but with a normal roentgenogram. All carcinoma does not show by x-ray. Next slide, please.

Here is an example of a patient with an abnormal roentgenogram but with no symptoms. This man had a respiratory infection for which he was treated successfully. After recovery, when the patient was entirely asymptomatic, a film of the chest was made to make sure that he had recovered fully, and here is a distinct abnormality in the right upper lung field. All indicated nonoperative diagnostic studies were carried out on this patient. Let's have the next slide, please.

Here is a lateral film. One sees a large round shadow here. The nonoperative studies were nondiagnostic, therefore operation was advised. Next slide, please. This proved to be an adenocarcinoma, which one can see clearly. Again, an example of a person with no symptoms and with an abnormal x-ray film. Now I mention that because when the x-ray picture is abnormal and shows a well circumscribed mass, the diagnosis of carcinoma of course is

extremely strongly presumptive; but when it is not sharply circumscribed, or well circumscribed, and when it is more irregular, it may be tuberculosis, unresolved pneumonia, or numerous other diseases. But, in particular our suspicions of carcinoma should be aroused sharply. Next slide, please.

This is an example of a person with no symptoms and with a normal roentgenogram of the chest, with carcinoma of the lung. This man was about 35 years of age and he had asthma. He had had asthma for some years. It was not localized asthma, that is, he had generalized wheezing. His physician thought that possibly some sympathectomy or parasympathectomy might be of value to him. In the course of study, bronchoscopy was performed, and he was found to have a small ulcer in the left main bronchus, which was examined by biopsy and it showed carcinoma. I am positive the ulcer was not the cause of the asthma, it wasn't causing the degree of asthma that he had. It was producing no obstruction whatsoever. He had no cough and no sputum. A left pneumonectomy was performed and again the diagnosis was confirmed. There was no metastasis, he lived without evidence of carcinoma for three years and then he died quite suddenly one day of asthma, marked bronchospasm, in just a few minutes. I think it is fair to show that film as one of a person with no symptoms, with a normal x-ray picture, but with proven carcinoma of the lung. Next slide, please.

This slide some of you may have seen before. I have talked about it before, but it never hurts to repeat a truth. We can review the story of this man with a proven carcinoma of the lung with a normal roentgenogram of the chest, the slides of which will be shown in a minute. This slide shows the photograph of a film of the chest of a man who had cough, sputum, and hemoptysis with both atelectasis and obstructive emphysema in the lower half of the right lung field. Bronchoscopy was performed, there was an obstructing tumor in the right lower lobe bronchus which was removed. It relieved the bronchial obstruction completely. After the tumor was removed, one could hardly see any abnormality remaining on the bronchial wall. It relieved the patient's

symptoms completely and immediately thereafter he considered himself entirely well. Microscopic examination showed carcinoma, he was advised to have a pneumonectomy, and he said he would think it over. Next slide, please.

This slide was taken in March 1947, five months later. It shows a perfectly normal x-ray picture of the chest of the same man with a proven carcinoma in the right lower lobe bronchus. After the five months elapsed, he decided to get somebody else's opinion, so he went to Duke Hospital. He was one of these people who liked to put the doctors on their mettle, so he didn't tell them about his past history. No abnormality was found and he was told that he could go on home. He lived in Hell Hole Swamp, and when his family returned for him, he told one of his doctors there that he knew those doctors in Charleston were damned fools, and he didn't need any "lung operation". Immediately the doctor inquired about who told him he needed a "lung operation" and why. After obtaining the rest of the history, a call was put in for me. The story was verified. They, too, advised him to have pneumonectomy. He waited two months more, to think it over. He returned there and a lobectomy instead of a pneumonectomy was performed, on account of pulmonary insufficiency. On examination of the specimen, it was extremely difficult to find the residual lesion in the right lower lobe bronchus, but it was there. It was a slow growing tumor. Goodness knows how long it would have taken to grow again. And there is a nice example of a patient with proven carcinoma of the lung, with no symptoms and with a normal x-ray film of the chest after the bronchial obstruction was relieved by incomplete removal of the tumor.

Concerning the treatment of carcinoma of the lung, we believe that if the lesion is resectable, the best method is removal of the primary tumor along with expendable normal surrounding tissue, and along with contiguous or remote sites of possible or actual spread that are accessible and expendable. This usually means pneumonectomy and a mediastinal lymphadenectomy. Occasionally lobectomy may be indicated in those with im-

paired pulmonary function.

There are additional methods of treatment. They include radiation, of course, and a chemical method, the administration of nitrogen mustard being the main one in vogue today. They may certainly be extremely valuable alone or in combination with each other, or with operation. The next slide, please.

This shows the photograph of an x-ray film of the chest of a man about 58 years of age. This was in June, 1957. He had had pain in the chest for about 4 months. About 3 weeks before we saw him, he developed edema of the face, indicating a superior vena caval obstruction. There were carcinoma cells in the sputum. There was some compression of the trachea. Bronchoscopy was not safe to perform by any means. The lesion was non-resectable, there being invasion of the superior mediastinum. Therefore he was given x-ray therapy. Next slide, please.

Here he is in October 1957 with a strikingly different appearance of the chest. The superior vena caval obstruction was almost completely relieved. He is not well, and he is going to die of carcinoma, but unquestionably he has had prolongation of life with comfort, which is what counts. X-ray therapy has been of great value to him. Next slide, please.

This is another example of a nice result from x-ray treatment. This lady was first seen in 1950. Her initial symptom was that while she was running down a street to catch a bus, she suddenly had marked shortness of breath and just fell to the ground. Apparently she had sudden paralysis of the right side of the diaphragm, that is the only reason we could find for the sudden shortness of breath and falling on the street. The slide shows an extensive shadow in the right upper lung field. The diagnosis was established by bronchoscopy and biopsy. The tumor was in the main bronchus and almost in the lower end of the trachea. It was considered to be non-resectable. She was given x-ray treatment. Next slide, please.

Now here is the same lady in July 1957. She still has carcinoma with involvement of the esophagus. She has had to eat soft foods. She had to have esophagoscopy once to remove food obstructing the esophagus. She has had

superior vena caval obstruction, with edema and cyanosis of the face to which she has adjusted. For some years now, this lady has led almost a normal life, and done everything that she wanted to do. The tumor in the main bronchus was removed bronchoscopically, but the main method of treatment was x-ray. I am sure she had a slow growing tumor, but certainly she has had an excellent palliative result for seven years. Next slide, please.

This is an example of probable carcinoma of the lung with treatment with nitrogen mustard. We saw this man in April 1956—he was about 45. About 4 months prior to this, he had pneumonia from which he did not recover. He lost weight and strength, and had this abnormal roentgenogram of the chest. Bronchoscopy was non-diagnostic; sputum examinations were non-diagnostic. We did not do biopsy of the lung. He had left axillary lymphadenopathy; biopsy of a node showed adenocarcinoma. We could find no other possible site for primary carcinoma except the lung, so we presumed that he had primary carcinoma in the lung. We gave him nitrogen mustard therapy, 0.4 milligrams per kilogram of body weight intravenously. About 6 months later I had a message from his doctor and family that he was getting along fine. He returned for re-examination. Next slide, please.

Here in April 1957 is the photograph of a practically normal roentgenogram of the chest. He had no axillary lymphadenopathy on either side. He returned again just a few days ago.

He is still entirely well, with no evidence of any residual carcinoma that I can find. It is not known that he had carcinoma in the lungs; we never did prove it; but he did have carcinoma in the left axilla. Nitrogen mustard occasionally does give rise to a nice result, even if sometimes it is temporary.

As for results of treatment, I would say that Dr. Wendell Levi on our house staff now is reviewing all of our cases of carcinoma of the lung. There were about 300 cases in the 10 years succeeding January 1946. Of those patients, there are now living approximately 15 in the private patient group and approximately 15 in the non-private group. That makes about 10 per cent in the entire group. Not all of those have been living 5 years or more, because in some the observation period has been shorter. It is believed that we will have essentially the same result that others have had, that is, in the entire group, about 7 or 8 per cent 5-year survival. Among those who have been operable and resectable, and in whom there was no gross tumor left in the thorax, and in whom there was no evidence of any distant metastasis, the 5-year survival will be about 25 per cent. Using no more than our present methods of diagnosis, it is believed that if we will keep the possibility of the carcinoma of the lung in mind more often and strive for earlier recognition, in another 10 years the end results can be distinctly better than they are now.

"If we had an adequate number of these paramedical co-workers right now, the effectiveness of physicians, surgeons, public health officers, and all comparable professional personnel would be remarkably multiplied. The need to train nurses in America today is distressing. To meet the existent need for trained nurses in military and civilian life would require four out of every ten girls in our graduating high school classes for some four or five years. Since six out of every ten marry within three years of graduation and since other occupations now compete with nursing, the requisite numbers of young girls to look after their brothers in military service are not being found. If the rationale of selective service were applied to the drafting of girls of eighteen for two

years of civilian nursing to match the military service of their brothers, we would create a notable and valuable reserve of nurses in this country for years to come, as well as a chance to open wards in our civilian hospitals now empty for the lack of nurses. I do not find any cogent arguments against such a resolution of the present immense problem of nursing care; the psychological resistance and the emotional resentment would be real, but just what do young women do in return for citizenship? And would not most of the future activities of young women of eighteen be done better if more had a nurse's training?"

Challenges to Contemporary Medicine. Alan Gregg.

THYROIDITIS

FURMAN T. WALLACE, M. D. AND RICHARD S. WILSON, M. D.

Thyroiditis is a relatively rare condition which is being seen with increasing frequency. There are three main types of thyroiditis which can be classified broadly as follows:

1. Acute thyroiditis or the suppurative type.

2. Subacute thyroiditis or de Quervain's disease which is also called pseudo-tuberculous or giant cell granulomatous thyroiditis.

3. Chronic thyroiditis, which can be divided into

- (a) Hashimoto's disease which is also called struma lymphomatosa and

- (b) Riedel's struma which also is called woody or ligneous thyroiditis.

1. Acute thyroiditis is simply infection and suppuration of the thyroid gland by pyogenic organisms. The treatment is essentially that of any acute inflammation, consisting of heat and antibiotics. If the process does not resolve soon, aspiration for culture and drug sensitivity is indicated. Surgery is indicated in acute thyroiditis only if abscess formation occurs. If an abscess develops, incision and drainage is necessary. This is accomplished without the usual flap dissection and without exposure of all the thyroid gland. The abscess is approached with as simple an incision as possible without opening any extra tissue planes to avoid spreading the infection.

2. The second type of thyroiditis is subacute thyroiditis or de Quervain's disease. This is also sometimes classified by its microscopic appearance and is called giant cell granulomatous thyroiditis or pseudotuberculous thyroiditis. The etiology is not definitely established, but the disease is probably due to a virus. A nonsuppurative inflammation is present and is characterized microscopically by the development of the giant cell granulomas with pseudotubercles and epithelioid cells. The onset is sudden, frequently following an upper respiratory infection. The course is long, and the process may last from two

weeks to several months.

The condition occurs more frequently in females than males (6 to 1) and usually occurs in the fourth or fifth decade. The other theory of etiology is that it may be due to autoimmunization against the patient's own colloid. It was interesting to note that thyroiditis can be reproduced in experimental animals injected with the saline extract of thyroid gland.¹

The cardinal symptoms in subacute thyroiditis are sore throat and pain on swallowing with frequent radiation of pain to the mandible and ears. Dysphagia may be severe during the early stage of the disease. A painful swelling of the thyroid gland appears with diffuse enlargement of one lobe or both and may extend from one lobe to the entire gland. At times severe prostration and high fever are present. The initial febrile period usually lasts from five to twelve days; however, persistent temperature elevation can be anticipated in many cases for several months.

The basal metabolic rate and plasma cholesterol levels may be within normal limits. The protein bound iodine is normal, while the radioactive iodine uptake is low. This is explained by the fact that colloid is still present giving the normal serum protein-bound iodine but that thyroid function is diminished, giving a low radioactive iodine uptake. The white blood count and sedimentation rate are usually elevated. A few patients may develop myxedema several months after the acute phase and will require thyroid replacement therapy. In the acute phase symptomatic treatment with local heat and bed rest are of value.

Subacute thyroiditis can frequently be improved through external irradiation of 500 to 1,500 r. Since the advent of cortisone and ACTH, prompt and dramatic response may be noted at times. Since x-ray therapy has a curative effect on a high percentage of cases without side effect, it should be considered superior to cortisone. In some cases combined therapy with cortisone and x-ray is worthy of

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further trial. Cortisone may produce immediate relief of the signs and symptoms, but it merely suppresses manifestation of the disease. Numerous recurrences may be seen.

Partial thyroidectomy will also effect a cure; however, since the disease tends to be self-limiting and radiation is frequently curative, operation is recommended only when the diagnosis is in doubt or pressure symptoms appear. Thiouracil may help in limiting production of colloid. The administration of antibiotics may be of value in prevention of suppuration.

3. Chronic thyroiditis is a broad classification and actually consists of two conditions. The first is Hashimoto's disease (struma lymphomatosa). This is a disease exclusively of females with an average age of 47. The onset is gradual and is frequently accompanied by hypothyroidism. Pressure symptoms may be present, and the gland is usually tender and enlarged and somewhat fixed. Actual myxedema may be present if the process has been of long standing.

The etiology has not been definitely established, but probably most of the cases are due to viral infection of the thyroid gland. The process is usually diffuse, and both lobes are frequently involved, and it does not tend to be nodular.

Treatment is indicated after the diagnosis has been established microscopically. Some authorities use needle biopsy to establish the diagnosis. It is essential that malignancy be ruled out. Many others use exploration of the thyroid gland and frozen section to rule out malignancy. After the diagnosis has been established microscopically, x-ray therapy is used. ACTH or cortisone may be of value. Surgical treatment, other than establishing the diagnosis, consists of decompression of the trachea. The isthmus and anterior portion of both lobes of the thyroid are removed. A subtotal thyroidectomy is not done because of danger to adherent structures.

The other type of chronic thyroiditis is Riedel's struma (woody or ligneous thyroiditis). The process consists mainly of fibrous replacement of portions of the thyroid gland. The etiology has not been established definitely, but the fibrosis of the thyroid gland can probably be due to different causes just

as it is in cirrhosis of the liver.

The symptoms are usually pressure symptoms and frequently tenderness of the thyroid gland. One-third of the cases occur in men. The average age group is 43. The gland is densely adherent, slightly enlarged and stony hard. The presence of a stony hard goiter is frequently the first and only symptom. Hypothyroidism may be present. Pressure symptoms occur later. Myxedema is always present later in the disease. Palpable lymph nodes do not occur.

Surgical exploration is required to differentiate the condition from carcinoma of the thyroid. The surgical treatment consists of relief of the pressure symptoms and is a means of diagnosis. The isthmus and anterior portion of both lobes are removed. The operation should always be conservative because of adherence of surrounding structures, particularly the recurrent laryngeal nerve.

Hypothyroidism can be anticipated in Riedel's struma. A close follow-up should be done post-operatively and thyroid therapy begun as soon as indicated. One should not wait for myxedema to be clinically established before beginning thyroid therapy. Instead the weight should be followed closely every week and at the first indication of weight gain or lassitude, thyroid therapy should be started.

There has been much speculation as to whether Hashimoto's disease may go on to Riedel's struma. It has been established that all of the cases do not. In our series there was one case of acute thyroiditis which went on nine months later to a clinically proven Riedel's struma. The difference between Hashimoto's disease and Riedel's struma may be summarized as follows:

1. Hashimoto's disease occurs almost entirely in women, whereas in Riedel's struma only two-thirds of the cases occur in women.

2. Hashimoto's disease is practically always bilateral, whereas approximately one-half of the cases of Riedel's struma are unilateral.

3. Riedel's struma is frequently associated with adenomata, whereas they are practically never seen in Hashimoto's disease.

4. The average age of patients with Hashimoto's disease is 47 years, and the average age of patients with Riedel's struma, which Ewing

considered to be the late stage of Hashimoto's disease, is 43 years.

We have reviewed 256 of our cases of thyroid disease which were admitted to Spartanburg General Hospital. In this series there were 21 cases of thyroiditis occurring in 20 patients. One patient with acute thyroiditis was later admitted with Riedel's struma. The incidence of thyroiditis in 256 cases which included all types of surgical thyroid diseases (248 had thyroidectomy) was 8 per cent. In other words, 8 per cent of our thyroid cases admitted have had thyroiditis. These cases have been reviewed and may be summarized as follows:

There were 21 admissions for thyroiditis. Five patients had acute thyroiditis. None of these required surgery. Four were female and

one male. This last case nine months later developed Riedel's struma which was proven microscopically.

There was one case of subacute thyroiditis or deQuervain's disease. This unusual case will be reviewed in some detail elsewhere.

There were seven cases of Hashimoto's disease: all were females. All were proven microscopically. There were eight cases of Riedel's struma which were proven microscopically. Thyroid therapy was required in most of these.

Summary

The three types of thyroiditis have been discussed. A review of 256 admissions with thyroid disease was made. The incidence of thyroiditis in this group was 8 per cent.

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Transposition of External Genitalia In A Case With Fanconi Type Deformity. Buford S. Chappell, M. D. (Columbia) *J. Urol.* 79:115, Jan. '58.

The Fanconi type of congenital deformity first described by Faneoni in 1926 and manifested by pancytopenia and multiple skeletal and other deformities often including genito-urinary tract, had by 1955, been described and reported in only about thirty cases. By 1955 only nine cases of transposition of external genitalia had been reported. The presence of two such rare anomalies in the same individual constitutes a medical curiosity. Such a case is reported in an infant admitted to the hospital for plastic surgery, and attention is called to the severe bleeding tendency of the patient with Fanconi type deformity and since genital anomalies are common in this disorder, it would be well to consider the possibility of pancytopenia (Faneoni type) before plastic surgery is done on the external genitalia of any infant.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Nodal Tachycardia

DALE GROOM, M. D.

Department of Medicine

Case Record—The day following an abdominal operation a middle-aged man complained of a sensation of rapid “throbbing” over the heart and in the neck, suggestive to him of a heart attack. The symptoms recurred several times and were observed to be associated with an abrupt increase in pulse rate and fall in blood pressure. Each time they subsided spontaneously within an hour or so. During one such attack the electrocardiogram illustrated here was recorded.

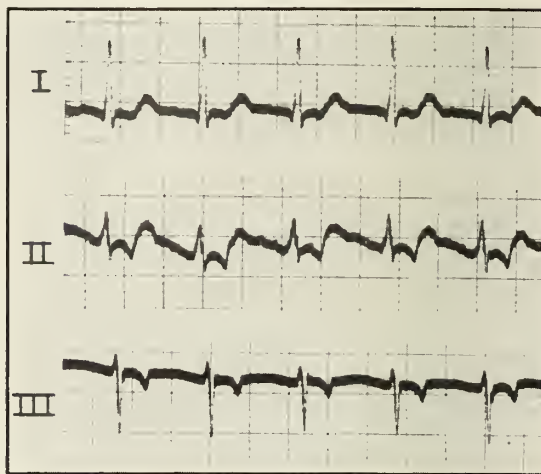
Prior to surgery the patient had been noted to have a pulse irregularity which an ECG had revealed to be due to frequent atrial ectopic beats with runs of atrial bigeminy. Quinidine in moderate dosage had controlled the arrhythmia, however the drug had been omitted from the surgical orders. At operation a metastatic carcinoma of the pancreas had been found and only a portion of the celiac ganglia had been resected, this as a measure for control of future pain.

The patient's postoperative course in the hospital was otherwise uncomplicated.

Electrocardiogram—The three standard leads reveal a regular rhythm at a rate of 125 beats per minute. Notable is the fact that the P waves fall after the normal QRS complexes where they are superimposed on the beginning of the T waves but are obviously inverted. Polarity of the P waves was reversed in other leads also; they were upright in aVr and inverted in aVf. All QRS and T wave complexes were similar to those in the preoperative tracing and were oriented in a horizontal (left) electrical axis.

Discussion—Two distinctive features are illustrated in this patient's electrocardiogram: a rapid rhythm emanating from the atrioventricular node, and retrograde conduction through the atria. Both were evident throughout the complete tracing. The rhythm is an A-V nodal one because the ventricular complexes are of normal width and configuration, occur at regular intervals, and are not immediately preceded by P waves nor any manifestation of atrial activity. Further verification of this is seen in the inverted P waves which follow the QRS complexes signifying that the same excitation impulse is transmitted after some delay in a retrograde direction through the atria.

An ectopic tachycardia is an abnormally rapid and usually regular rate of cardiac activation arising from



a focus outside the normal pacemaker, the sino-atrial node. The pacemaking function of the heart is usurped by repetitive stimuli from an ectopic focus which may be located anywhere in the atria, the A-V node, the ventricular musculature or its conduction system. Such tachycardias are usually paroxysmal in nature, beginning and ending abruptly. The degree to which they interfere with the mechanical function of the heart is largely dependent upon the resultant rapidity of the ventricular rate and the duration of the attack. (Conceivably the reversed sequence of atrial and ventricular contractions in this case might itself impose an additional impairment of function). Different areas of the heart tend to have different inherent rates of rhythmicity—a point of some clinical importance—and in general these rates tend to be higher in the younger age groups. That for a nodal tachycardia characteristically ranges from about 120-200 beats per minute.

Occasionally a much slower rhythm is seen to arise from the A-V node, the so-called “nodal rhythm”. When impulses fail to reach the node, either because of cessation of atrial activity as by depression of the normal pacemaker, or because of a complete atrioventricular block, a nodal or ventricular pacemaker must take over if cardiac function is to be maintained. Such a rhythm is actually an escape mechanism, as are the isolated “nodal escape” beats which often terminate periods of asystole due to sinus arrest. They can be produced experimentally by depression of the sino-atrial node with drugs or by vagal or carotid sinus stimulation. Nodal tachycardia, on the other hand, is thought to represent an actual enhancement of activity of the atrioventricular node. Some part of the junctional tissue comprising it gives forth rapid

repetitive stimuli. These of course reach the ventricles along their normal conduction pathways—hence the usual normal ventricular complexes are inscribed in the electrocardiogram.

Whether the P waves fall before, during or after the QRS complexes is probably determined by the particular site of origin of the impulses in the junctional tissue. If they precede the QRS the P-R interval is shortened; if they follow, as in this case, they quite likely arise in a portion of the node below that which imposes the normal delay in A-V conduction. In any event the polarity of the P waves is reversed in retrograde conduction. P waves which are inverted in aVf and upright in aVr denote activation of the atria in a direction from the left leg upward toward the right arm.

Not always are the P waves as well demarcated as in this tracing. In fact, commonly they fuse with the QRS or are obscured in the preceding or following T waves. In such instances it becomes difficult to differentiate a nodal from an atrial tachycardia and the term *supraventricular tachycardia* is commonly used to designate either origin. Although it may be of only academic interest, the differentiation of these arrhythmias can usually be accomplished with an esophageal lead in which the P waves are effectively magnified, being recorded as large complexes similar to the QRS deflections in limb leads.

Ectopic tachycardias are usually transitory and often recurrent. The paroxysms may last minutes, hours, or even weeks. Of their clinical significance it can be said that, generally, those of ventricular origin are the most ominous and those from the atria the least. None of them is necessarily indicative of structural heart disease. Attacks of paroxysmal tachycardia arising from the A-V node or above can often be terminated quickly by the clinical maneuvers of pressure on the carotid sinus or eyeballs, or induced vomiting. Quinidine remains one of the most effective measures of treatment and prevention of the ectopic tachycardias.

ECTOPIC PREGNANCY

A Diagnostic Problem

A Case Report

EDWARD J. DENNIS, M. D.

Department of Obstetrics and Gynecology

A 24 year old gravida 1, para 1, was seen in the clinic on the first of July, 1957, with complaint of vaginal bleeding of 6 weeks duration.

Menarche occurred at 11, periods every 28 days lasting from 2-5 days. Her last normal menstrual period was on May 15, 1957. She denied dysmenorrhea or any difficulty with menses. She had one child delivered 4½ years ago with completely uncomplicated antepartum course and delivery. No contraceptive measures were used for the past two years.

Past history was non-contributory and there had

been no surgical procedures.

Present illness began at expected time of menses in June at which time she noticed dark brown vaginal discharge. This persisted for 3 weeks at the end of which time she went to the bathroom to void and fainted while sitting on the commode. She was taken to her physician who immediately placed her in the hospital with a presumptive diagnosis of incomplete abortion. Dilatation and curettage done the following day yielded only normal endometrial tissue and this was confirmed by pathological study. No adnexal masses were noted on examination. She was discharged from the hospital on the second postoperative day in good condition.

Subsequent course characterized by a short period of very little bleeding but a week later bleeding increased though was still not of sufficient quantity to create any alarm. During this course of events, at no time was there any significant abdominal pain noted.

At the time of admission, significant findings were limited to the pelvis. Bartholin's and Skene's glands and the urethra were negative. The introitus was multiparous but showed good perineal support and tone. There was a minimum amount of dark brown blood in the vagina. The cervix was normal and closed, the uterus normal in size and configuration and freely movable. In the left adnexa was a soft 7.5 cm. mass extending into the culdesac on the left. Minimal tenderness was noted on compression of the mass on rectovaginal examination. A presumptive diagnosis of old ruptured ectopic pregnancy was made and the patient was admitted to the hospital. Culdoscopic examination was contemplated but due to the position of the mass in the culdesac and the probable diagnosis, this was abandoned. Paracentesis of the culdesac yielded two to three small old blood clots.

Laboratory studies including complete blood count and urinalysis were normal.

At laparotomy, the left tube was involved in a 7 cm. mass of organizing blood clot but no definite rent could be found in the fallopian tube. The right tube, both ovaries and the uterus showed no unusual features. Left salpingectomy and incidental appendectomy were done without difficulty.

On gross examination by the pathologists a 2.5 cm. rent was found in the middle of the tube through which protruded a 4.5 cm. mass of hemorrhagic tissue. Microscopic sections confirmed the presence of chorionic villi adjacent to tubal epithelium.

The patient's postoperative course was uncomplicated and she was discharged from the hospital on the sixth postoperative day.

Discussion: A patient presenting the classical signs and symptoms of ectopic pregnancy, namely, of amenorrhea, severe abdominal pain of sudden onset, vaginal bleeding, and varying degrees of peripheral circulatory collapse offers no diagnostic problem. Conversely, the patient with intermittent abdominal pain and irregular vaginal bleeding associated with a leaking or old ruptured tubal pregnancy, taxes the

diagnostic acumen of the most experienced physician.

Undoubtedly the most important diagnostic facility available is that any physician seeing a female during her reproductive years, presenting with a complaint of irregular vaginal bleeding with or without abdominal pain, must consider ectopic pregnancy high on the list in a differential diagnosis.

Laboratory and ancillary diagnostic procedures have definite limitations as an aid in reaching a conclusive diagnosis.

Biological tests for pregnancy are of little value since the circulating gonadotrophin level may not be sufficient to produce a positive test. Too, the presumptive diagnosis of pregnancy made by such test is obviously of little value since the site of pregnancy is not determined, and may be intrauterine, or, in rare instances, concomitant intrauterine and ectopic.

Endometrial biopsy and dilatation and curettage are of practically no value since one is always hesitant to enter the endometrial cavity in a woman suspected of being pregnant. Of even greater significance is that studies of endometrial tissue, obtained from patients with proven ectopic gestations, could not be differentiated from the endometrium of a normal menstrual cycle in 75 per cent of the cases. The passage of a decidual cast has been of value in the past but now certain drugs (Enovid) are known to produce such casts in the absence of pregnancy.

Culdesopic examination using the scope devised

by Deeker has definite limitations and is often impractical on the basis that the technical difficulties involved require a certain proficiency in its use.

Paracentesis of the culdesac with an 18 gauge spinal needle has proven of value in confirming the presence of associated hemoperitonium in suspected cases before laparotomy. This may seem superfluous but many women are subjected to laparotomy only on a suspected diagnosis; and the absence of blood in the culdesac, while obviously not ruling out ruptured ectopic, makes such a diagnosis unlikely.

Pelvic examination in the acute case is of value in detecting marked and exquisite tenderness on manipulation of the cervix. Fullness and crepitation produced by blood in the culdesac are of value when found. In the old ruptures, the mass is not diagnostic unless crepitation of old blood can be detected.

Summary: A case of ruptured tubal pregnancy of three weeks duration is presented.

The most valuable diagnostic facility available is a high index of suspicion on the part of the physician in seeing any woman in her reproductive age with abnormal vaginal bleeding with or without abdominal pain.

Various laboratory and other diagnostic procedures have definite limitations as an adjunct in diagnosis.

Ruptured ectopic pregnancy continues to contribute significantly to the percentage of maternal deaths throughout the country, and many of such deaths are preventable.

"One more among the many consequences of the present military situation impinges on American medicine. We are adding veterans at the rate of 30,000 to 46,000 a month—veterans returning to civilian life after a fairly impressive experience of medical care given at government expense. They then join for the rest of their lives the ranks of those eligible for care by the Veterans Administration. With some 22,000,000 of the electorate now eligible for Veterans Administration medical care, and not without ways to express themselves politically about it, I see in this situation a powerful force pushing for wider and more explicit acceptance of medical care maintained by taxation rather than as a boon given to the poor in the name of charity or purchased by the rich or even prudently assured through prepayment on the voluntary insurance basis."

Challenges to Contemporary Medicine. Alan Gregg.

"I want to point out that in the light of what medicine has done and can do for us, our reluctance to pay more—much more—for medical care and protection is simply fantastic. My point, in briefest form,

is that the table of life that traditionally has rested on the tripod of food, clothing, and shelter can now rest more securely and more reasonably on four legs—food, clothing, shelter and medical care. The last and newest leg cannot sensibly be much shorter or weaker than the others. Keeping well and alive has become, without our realizing it, part of one's living expenses. We shall solve nothing by insisting that if we must spend \$2.00 a day or more on food we cannot afford 28 cents a day for medical care. We shall get to no pleasant destination by improvidence or by regarding medical protection as an avoidable luxury. . . .

"In essence, my theme is this: the layman does not realize that modern medicine could bring him immense advantages if only he would consider health in a sensible perspective relative to the other expenses of keeping alive. A practical way lies open now to take advantage of what Great Medicine could do for us. Voluntary prepayment is the path, and each one of us could be a pathfinder and a contributor to a great new development."

Challenges to Contemporary Medicine. Alan Gregg.



PRESIDENT'S PAGE

Every physician should strive to be the best doctor possible by continually improving his medical knowledge and skill. He should make available to his patients and colleagues the benefits of his professional attainments.

As doctors, it is our responsibility to continue professional education throughout our lives, assume active roles in medical organization affairs, live by the highest ethical standards of the medical profession, and help educate the public as to the socio-economic as well as the scientific side of medicine.

Medical progress proceeds at a fantastically rapid rate and every doctor must find time to constantly inform himself on scientific advances in his field. National, state, district and county medical society meetings, hospital staff conferences, medical periodicals, postgraduate and home study courses offer ample opportunity for continuation of professional education. One or more of these methods is within easy reach of every physician in the United States of America. Doctors should spotlight the truth about medical education and bring home the fact that physicians help train more and more doctors so that today our medical schools are graduating more physicians than ever before.

Professional jealousy and internal wrangling have no place in a profession where ethical considerations are foremost. Critical comments about a fellow practitioner should be beneath the dignity of every physician resulting in the ubiquitousness of harmony in our ranks. Keeping this in mind at all times, we can point out the advantages of prepayment insurance plans to our patients and also the inherent dangers in a governmental system of medical care which will inevitably lower our present standards.

Each year your state association is endeavoring to improve and present a scientific program that will attract the attention of every physician in the State. I would like to take this opportunity to congratulate Lesesne Smith and his program committee for the interesting and instructive type of scientific papers presented at our annual meeting in Myrtle Beach last month.

R. L. Crawford, M. D.

Editorials

SOUTHERN POSTGRADUATE SEMINAR

An expanded version of the former Southern Pediatric Seminar will open its session on July 7 and run through July 26. This long established and highly regarded institution dates back many years in its true service to the profession. Devised and nurtured by Dr. Lesesne Smith, father of our immediate past president, and carried on by the latter with the assistance of many professional friends, it has provided excellent postgraduate instruction to many physicians, particularly to the general practitioner in the southern area of the country.

This unusual institution represents a labor of love on the part of its founder and of the many professional people, both in the professorial and the practicing class, who have given their services and expenses over many years in the past. Its presentations are informal and interesting. It is an excellent objective for anyone seeking combination of summer instruction and relaxation.

THE ANNUAL MEETING 1958

The Annual Meeting of the Association, held at Myrtle Beach on May 13, 14, and 15, was a very satisfactory occasion. Attendance was good and everybody seemed to have an enjoyable time.

Business was dispatched neatly by the president, Dr. Lesesne Smith, and Dr. R. L. Crawford took office at the end of the meeting. The only matter of business which was controversial was that concerning establishment of a liaison committee between the Association and the Medical College, and this was decided rather positively in the negative.

Entertainment both official and individual seemed to be adequate for all.

Those in charge of the arrangements of various kinds are to be commended highly.

The Association named Dr. William Weston, Jr. of Columbia as its president-elect to take

office next year.

The elections, feature of Wednesday's session of the annual convention, saw Dr. Henry C. Robertson, Jr. of Charleston named vice president and these officers re-elected: Dr. Robert Wilson of Charleston, secretary, and Dr. J. Howard Stokes of Florence, treasurer.

The incoming president is Dr. R. L. Crawford of Lancaster, who succeeds Dr. D. L. Smith of Spartanburg.

The other officers named:

Dr. George D. Johnson of Spartanburg, delegate to the American Medical Association, Dr. Charles N. Wyatt of Greenville, alternate delegate.

Dr. A. F. Burnside of Columbia, Dr. John M. Brewer of Kershaw, and Dr. J. H. Gressette of Orangeburg, all were re-elected to three-year terms as members of the council.

Dr. Weston Cook of Columbia, Dr. Roderick Maedonald of Roek Hill and Dr. W. R. Tuten, Jr. of Allendale, all re-elected to three-year terms as members of the medical committee.

The following men were nominated for posts which will be appointed by the Governor:

Dr. J. Howard Stokes of Florence, to the executive committee of the State Board of Health to fill the unexpired term of Dr. W. R. Mead of Florence who resigned.

Dr. George R. Wilkinson of Greenville and Dr. W. R. Tuten of Fairfax, to succeed themselves on the State Board of Medical Examiners.

Dr. R. E. Madden of Columbia, to succeed himself on the State Board of Examination and Registration of Nurses.

Dr. Pierre La Borde of Columbia, to succeed himself on the Hospital Advisory Council of the State Board of Health.

The convention ended Thursday night following the annual banquet when Maj. Gen. Leonard D. Heaton, United States Medical Corps spoke. He is the commanding general

of the Walter Reed Medical Center, Washington.

Next year's meeting will be held in Columbia.



DR. WILLIAM WESTON, JR.
PRESIDENT-ELECT

NEWS

Alexander M. Sloan, M. D. announces the opening of his office for the practice of urology at 111-A Rutledge Avenue, Charleston.

MEDICAL COLLEGE GETS HEART RESEARCH GRANT

Dr. Edwin Boyle, Jr., Medical College of South Carolina, is the recipient of a grant from the American Heart Association.

He is to conduct research in South Carolina on diseases of the heart and blood vessels, it was announced by Dr. George R. Wilkinson, president of the South Carolina Heart Association.

This award was among 183 totaling \$1,433,147, given to scientists throughout the country under the national research support program of the American Heart Association and its affiliates. Of the Heart Fund contributions provided by the South Carolina Heart Association to support the national program aimed at combating the cardio-vascular diseases, more than 50 per cent is allocated to research.

Dr. J. J. Cleckley, of the department of Neuropsychiatry, Medical College of S. C., was recently elected president of the South Carolina Branch, American Psychiatric Association.

Other new officers are president-elect, Dr. Joe E.

Freed, S. C. State Hospital, Columbia; and secretary-treasurer, Dr. Joseph H. Marshall, Medical College of S. C., Charleston.

Dr. William S. Hall, superintendent of the S. C. State Hospital, is retiring president, and Dr. Joe E. Freed is retiring secretary-treasurer.

New officers were elected following a meeting devoted to psychiatric subjects and matters to be considered at the annual convention of the American Psychiatric Association in San Francisco in May. Dr. Freed is the delegate to the 1959 session of the APA in Philadelphia.

Two South Carolinians and the president of the University of Virginia will be recipients of the honorary Doctor of Laws degrees at commencement exercises of the University of South Carolina May 30, according to Dr. Robert L. Sumwalt, acting president of the University.

To receive honorary degrees are Charles Westfield Coker of Hartsville, executive vice president of Sonoco Products Co. and a 1929 graduate of the University; Dr. Austin Talley Moore of Columbia, nationally known orthopedic surgeon; and President Colgate Whitehead Darden, Jr., of the University of Virginia, who will deliver the commencement address.

DR. MOORE

Dr. Moore was graduated from Wofford College with the A. B. in 1920, where he was elected to Phi Beta Kappa, and from the Medical College of South Carolina with the M. D. in 1924. He did post-graduate work at orthopedic surgery at the University of Pennsylvania from 1925 to 1927. After serving as intern and resident at hospitals in Charleston, Columbia, and Philadelphia, he entered private practice as an orthopedic surgeon in Columbia in July, 1927. He established the Moore Clinic in 1939. He is the originator of methods of treatment of hip fracture and of spinal discogenetic syndrome.

The American Psychiatric Association has announced a \$100,000 grant from the Smith Kline & French Foundation to continue the Foundation's Fellowships in Psychiatry through 1960.

These fellowships were established in 1955 with a three-year, \$90,000 grant from the SKF Foundation, which is principally supported by contributions from Smith Kline & French Laboratories, Philadelphia pharmaceutical firm. The program is administered by a committee appointed by the American Psychiatric Association.

In announcing the new grant, the A. P. A. said that more than 150 physicians and medical students already have benefitted from SKF Foundation Fellowship awards. The programs have ranged from a study of suicide rates to extension training programs in psychotherapy and psychosomatic medicine.

For example, almost one-third of the original \$90,000 grant was used to enable staff psychiatrists from state hospitals to take advanced training at some of

the nation's leading psychiatric training centers.

S. C. VOCATIONAL GROUP APPOINTS MEDICAL BOARD

A statewide Medical Advisory Committee of the South Carolina Agency of Vocational Rehabilitation was named yesterday.

J. C. Horne of Denmark, chairman of the agency, listed the following committee members:

Dr. George Adickes, Rock Hill, internal medicine; Dr. A. T. Moore, Columbia, orthopedist; Dr. Luther Martin, Charleston, neurologist; Dr. J. K. Webb, Greenville, general surgeon; Dr. Joe Freed, Columbia, psychiatrist; Dr. L. P. Thackston, Orangeburg, urologist; Dr. R. E. Edmondson, Anderson, anesthetist; and Dr. G. S. T. Peeples, state health officer.

S. C. SURGICAL GROUP ELECTS DR. LIPPERT

Dr. Karl Borgan Lippert of Columbia was elected president of the South Carolina Surgical Society at the 10th annual meeting of society held in Columbia.

Doctor Lippert succeeds Dr. Angus Hinson of Rock Hill.

Other new officers include Dr. Henry Rigdon of Florence, vice president; and Dr. William Brockington of Greenwood, re-elected secretary-treasurer.

Dr. R. Randolph Bradham was elected to membership in the society.

Guest speaker at the convention was Dr. William G. Hamm of Atlanta, Ga., associate professor of plastic surgery at Emory University medical school.

Operative clinics were held at the various hospitals in Columbia Saturday morning by the Columbia members of the society for visiting members.

Surgical papers were presented by several Columbia doctors during the Saturday morning session.

Dr. Richard W. Thomas opened an office in the Saluda Gardens Shopping Center, 1207 Sunset Boulevard, in April.

Dr. Thomas is entering the practice of general medicine in West Columbia after just completing his internship at Columbia Hospital. He was graduated from the Medical College of South Carolina in April, 1957.

Prior to that time he had graduated in Pharmacy at the University of South Carolina and was employed as a pharmacist at Gasque's Drug Store and at the Dutch Fork Drug Store while at the University. During the summers he was employed at Nye Drug Store in Myrtle Beach.

Dr. Thomas served in the U. S. Army from 1945 to 1948 as a Pharmacist and was again called into service in 1950 and 1951 as an ambulance driver in the medical corps.

Dr. Francis X. MacAuley, for the last four years

chief of laboratories at the U. S. Naval Hospital in Charleston, has recently begun the practice of pathology at the Orangeburg Regional Hospital.

The arrival of Dr. MacAuley in Orangeburg is a great step forward for medicine in this area as the community has never had a practitioner in his branch of medicine before.

CIVIL DEFENSE

Medical civil defense in time of disaster was the subject of discussion at a meeting in Columbia.

The meeting was sponsored by the South Carolina Medical Association's committee on civil defense, Dr. Charles N. Wyatt of Greenville, chairman. Representatives of the leading agencies in the state providing facilities relating to disaster relief attended.

Among the speakers were Dr. Lester M. Petric, deputy director of Georgia Civil Defense Health Service. Dr. William J. McAnally, regional medical officer for federal civil defense, and Dr. Joseph A. Hertell of Atlanta, area medical officer of the American Red Cross. Also on the program will be Greenwood County Senator Alec H. Woodle, who sponsored a civil defense reorganization bill in the last session of the state legislature.

Dr. William S. Lyles, Winnsboro surgeon attended an important meeting near Atlanta, Ga. American policy in the Far East was discussed by 75 Southern leaders at a four-day conference, April 10-13. The conference was sponsored by Emory University, in cooperation with the Eisenhower-founded American Assembly of Columbia University.

DR. SHERIFF WINS HONOR

Dr. Hilla Sheriff, Director of the Maternal and Child Health Division, has brought another honor home. She was chosen President-Elect of the Association of State Maternal and Child Health and Crippled Children Directors at its Biennial Meeting held in Washington, D. C., on March 26 and 27. The purpose of the meeting was to exchange ideas and to learn specific programs and studies.

UNIVERSITY OF SOUTH CAROLINA 1ST CONFERENCE ON COMMUNITY PROBLEMS RELATED TO ALCOHOL

JUNE 25-27, 1958

RUSSELL HOUSE

COLUMBIA, S. C.

AS SEEN BY CAREW RICE



D. LESESNE SMITH
Retiring President



WILLIAM WESTON, JR.
President-elect



R. L. CRAWFORD
President



JOSEPH P. CAIN
Chairman of Council



BLUE CROSS . . . BLUE SHIELD



South Carolina Blue Cross and Blue Shield both operated in the black in 1957. The significance of that is not as good as it seems at first glance. Such encouraging results were possible because of the enthusiastic reception which the Dread Disease Endorsement received and the favorable experience which the Plans have had with it. There is still some evidence of unusual and unnecessary over-utilization, and the unfavorable experience with some groups has caused an increase in rates for those groups.

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An interesting experience with Blue Cross utilization has recently been reported by the American Hospital Association. Statistical study revealed a 19 per cent difference in annual hospital admission rates for two groups in greater New York. Both had Blue Cross coverage, but different medical care insurance. The Hospital Insurance Plan of Greater New York gave comprehensive medical care in the hospital, in the home, and in the office. Blue Shield gave surgical and maternity care in the hospital only and one-third of the Blue Shield members had medical coverage for in-hospital care. The average duration of hospital stay per admission in the two groups was essentially the same. The number of admissions per 1,000 members was higher in the Blue Shield group than in H. I. P.

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There is a paradoxical situation in our coverage of tonsillectomies and some other more or less minor surgical procedures. Blue Shield pays the same allowance for tonsillectomies done in the doctor's office and for those done in the hospital. The doctor absorbs a considerable expense when he operates in his office. This expense would be hospital expense if the operation were done in the hospital. Many surgeons pay the anesthetist's fee when they operate in the office under general anesthesia. The anesthetist's charge is added to the patient's bill, and the surgeon attempts to collect it. Blue Shield pays no fee for anesthesia administered to other than in-hospital cases. Non-group surgical and maternity Blue Shield contract pays no anesthetic fees. Many surgeons who remove tonsils in their offices hesitate to call a colleague in to give an anesthetic when the collection of a fee is in doubt. Furthermore, to do so without the surgeon guaranteeing payment of the fee would be contrary to a well established custom in some areas.

Many surgeons would prefer to operate in their offices. However, to do so would deprive the patient of his Blue Cross benefits and would force the surgeon to charge a greater fee than the Blue Shield fee allowance. Otherwise he would receive much less

effective remuneration, because of hospital-like expenses absorbed by him.

Two and possibly three unfortunate results have come from this situation. Many otolaryngologists are refusing to operate on patients who insist on going to the hospital. Many patients are going to the hospital for relatively minor surgery because of eligibility for Blue Cross hospital benefits. This causes an increased and expensive utilization. Some otolaryngologists have refused to sign participating physician's agreements because of their unwillingness to accept the Blue Shield allowance for tonsillectomy done in their offices, because of increased expense, or for operation done in the hospital, because of difficulty in posting cases at an hour convenient to them.

This is an important matter and one that the Central Professional Service Committee should study. My suggestion is that anesthesia benefits be allowed for any surgical procedure, covered by Blue Shield, and that Blue Cross extend the coverage now allowed for surgery done in the out-patient department of the hospital to covered surgical procedures done in the doctor's office. I believe that this will be more equitable than the present practice; that it will lower hospital utilization by Blue Cross members; that it will seem fairer to both the patient and the surgeon; and that there will be little if any increase in insurance claims expense. My suggestions are recommended for study by management. If you think well of them, write the home office, directing your letter to Mr. Starin.

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The medical care of the aged is a pressing one and one which must be solved. Although many and perhaps most old people are medically indigent, it is not fair to think of them as charity cases when they get sick. Too often their children are unable or unwilling to provide the medical care which they need.

The medical plight of this segment of the population makes a seemingly logical demand upon the insurance principle for solution. The Forand Bill, which would seek to tie in medical care of the aged with the Social Security System, is not a solution which would be acceptable to the American people nor to the medical profession. It is not an application of the insurance principle; it is not voluntary; it is not a contractual benefit; it is governmental medicine.

Some reasons why the aged are not good health insurance risks were recently mentioned. Trauma as a cause of death and incapacity in persons past 65 is surpassed by cancer and cardiac and vascular accidents only. Elderly people account for 40 per cent of all those incapacitated by injury and disease for three

months or more. Even when elective surgical procedures are contemplated, there must be exercised most detailed and judicious pre-operative care.

No doubt reliable actuarial data can be developed so that the insurance principle may be applied to the medical care of these elderly citizens. However, at the moment, it appears that to insure them would require application of the paid-up principle by retirement time. This in turn would require longterm and consistent planning on the part of the individual, widespread distribution of risks, the accumulation and wise investment of large reserves. When all of these requirements are brought into the picture, is it any wonder that many thoughtful people think that compulsion is a necessary factor, and that that in turn would have to be universal in application, and finally that only the government has the power to provide the requirements. So what?

J. Decherd Guess, M. D.

BLUE CROSS — BLUE SHIELD

Robert E. Tomlin has been named manager of physicians relations, William Sandow, Jr., executive director of Blue Shield, announced recently. He assumed his new duties April 1, 1958.

His appointment to the newly created position marks the significant growth of Blue Shield membership in South Carolina and reflects recognition of the ever-increasing complexities of providing health care on a voluntary, prepaid basis. He will function in a liaison capacity between participating physicians and the Blue Shield Plan.

Bob's job has many important phases. His responsibility includes the broad duties of interpreting Blue Shield benefits and policies, working individually with physicians' secretaries and office personnel, as well as assisting in the planning and conducting of Blue Shield—Medical personnel seminars from time to time.

Prior to his new appointment, Bob achieved an outstanding record as a Blue Cross-Blue Shield sales representative since becoming associated with the plans in the Columbia district nearly three years ago.

Bob attended the University of Miami and the University of South Carolina.

Married to the former Miss Carol Garrison of Rock Hill, they have one child, Lora, and reside at 27 Fisher's Mill Road, Columbia.

Bob plans to eventually visit each participating physician's office. However, should you wish to see him earlier, just drop him a note. He will be happy to meet with you.

Thomas E. Jeffcoat was recently appointed manager of hospital relations for the South Carolina Hospital Service Plan. He was selected for this position on the basis of his educational background and excellent record as a Blue Cross - Blue Shield enrollment representative.

Tom is a man-on-the-go. Although he has served

his new capacity for only about three months, he has already traveled more than 8,000 miles and visited over forty hospitals one or more times. Basically, Tom's job is a "listening post" and "transmitter" for Blue Cross and hospitals alike.

In addition, Tom is available for answering questions regarding Blue Cross benefits, claims, hospital reimbursement formulae, and cost statements. He also works closely with hospital personnel who handle the mechanics of Blue Cross claims and procedures.

Tom graduated from the school of business administration of the University of South Carolina with a BS degree in accounting. Prior to attending the university, Tom had three years experience as a navy hospital corpsman.

He is married to the former Miss Barbara Bowers of Ft. Lauderdale, Florida. They have two children and reside at 1724 Inglewood Drive, Columbia, S. C.

Although Tom has already had the opportunity of meeting a large number of administrators and others in the field of hospital administration, he is looking forward to visiting each Member Hospital approximately every three months. However, Tom stands ready to visit any hospital with a minimum amount of notice.

ANNOUNCEMENTS

THE SOUTHERN POSTGRADUATE SEMINAR (formerly the Southern Pediatric Seminar) will be held in Saluda, North Carolina in July. Beginning on July 7, it will include in its first week a discussion of pediatrics and internal medicine; in its second week a pediatric program; and in its third session, ending July 26 to complete the three-week term, a consideration of obstetrics and gynecology. Credit in category 1 (35 hours a week) is given by the American Academy of General Practice. Enrollment may be for one week or more.

The Seminar affords excellent opportunity for instruction and recreation. Accommodations may be had in Saluda or nearby. Expenses are \$35.00 a week for registration, and are tax deductible.

For details write to Mr. M. A. Owens, Secretary-Treasurer, Saluda, N. C.

A revised list of films available through the A. M. A. motion picture library has been prepared and copies are available upon request from Motion Pictures and Medical Television of the American Medical Association. This catalog lists 87 medical films suitable for showing to medical societies, hospital staff meetings and other scientific groups. This catalog also includes 57 health films of interest to physicians who may be called upon to speak before lay audiences such as service organizations, Parent-Teachers' Associations, etc.

The following letter has been received.

Announcement and Invitation

The American Medical Association, through its Council on National Defense, is sponsoring its SIXTH ANNUAL NATIONAL MEDICAL CIVIL DEFENSE CONFERENCE on Saturday, June 21, at the Sheraton-Palace in San Francisco.

This is to extend you an invitation to attend this year's conference. There is no registration fee or other charges except the luncheon which will be \$4.00 per plate. Luncheon tickets may be obtained during the registration period Saturday morning, June 21. However, I urgently request that you complete and return the advance registration card which is enclosed. This will be most helpful to me in making the necessary arrangements for the conference and the luncheon.

In addition to a copy of the program, I am enclosing an informational release which explains two additional medical civil defense programs to be presented in San Francisco on June 19-20. We would appreciate your assistance so that these meetings and test exercise are widely publicized and if you could arrange to have the information published in such publications as are available through your office it would be extremely helpful.

There is a definite need for increased medical civil defense preparedness and programs of this type should be encouraged and attended. I sincerely hope you can attend and will assist us in publicizing the programs.

Most sincerely,
Frank W. Barton
Secretary, Council on National Defense

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MEDICAL LECTURE TOUR TO ASIA

The Asia-Pacific Academy of Ophthalmology is sponsoring a good will tour to countries of the Orient following the International Congress of Ophthalmology in Brussels in September, 1958. The purpose of this tour, which is to last approximately one month, is to hold joint meetings with ophthalmologists in Pakistan, India, Thailand, the Philippines, and Hong Kong. It is expected that this good will tour will create much interest among physicians in the countries to be visited and contribute greatly to American-Asiatic medical rapprochement.

Those desiring to participate in the postgraduate lectures and seminars on medical subjects pertinent to ophthalmology should contact

William John Holmes, M. D., Liaison Secretary,
Suite 280, Alexander Young Building,
Honolulu 13, Hawaii.

Inquiries regarding travel arrangements should be sent to

Compass Travel Bureau,
55 W. 42nd Street,
New York 36, New York.

PERSONALITIES

DR. CHAMBERS IS MAN OF 2 CAREERS

Few men have one mediocre career, much less two good ones.

But if Dr. G. W. Chambers of Anderson were a bragging man he could boast of two distinct workaday lives, one beginning at the age of 20 and the other at 47.

At 83, Dr. Chambers is in the coasting years of the career he loves best, doctoring. He still maintains a limited practice at the cluttered Benson Street office where he lives and has daily office hours.

Few of his friends or patients are aware that he had a successful career as school teacher and principal before going back to four years of medical school at the age of 43.

He always had intended to be a doctor, and actually set out on a pre-medical education before one of the early "depressions" made him turn to a teaching degree in 1895 so he could teach and earn enough money to go on to medical school in 1918, some 23 years after he had graduated from Peabody College with a license to teach in the entire South.

He was at the University of Michigan School of Medicine only one year when he was called on to teach anatomy to younger students because he was at the top of his class. His record was so good he was not required to take final examinations, either.

"And I would like to point out that I worked every step of the way, often seven days a week during the four years at med school," Dr. Chambers says.

From there on, when he came back to Anderson to set up his practice, Dr. Chambers had little time for outside activities, but he still managed to maintain a stout interest in civic affairs, church work and music.

Dr. Chambers has had some good and bad times as a doctor "but I wouldn't trade either for any other career."

The Indiana native — he was born March 28, 1875 in a small Indiana town and moved with his preacher father and family to North Carolina later — had his finest day early in his medical career.

He walked into Anderson Hospital on another case one day and a mother frantically called attention to a child who was turning blue and had lost consciousness from lack of air. She told him the child had swallowed a metal bottle cap.

Dr. Chambers says he reached into the child's

throat and extracted the cap with hemostats. The child quickly regained his normal color and consciousness.

"The mother didn't offer to pay or even thank me," he says, "but it was the most satisfying moment of my career when that child breathed again."

Dr. Chambers had his ugly days too. He was once on the go and busy for 72 hours straight without sleep.

"I checked into the Plaza Hotel, told them to give me a room way in the back and not to disturb me for any reason," Dr. Chambers recalls. "I slept straight through for 18 hours."

In the 1918-22 influenza outbreaks, Dr. Chambers, like his colleagues, often had up to 100 patients seriously ill at one time. Somehow he scraped through without coming down himself.

Possibly his busiest period came a number of years later, however. In 1930 Dr. Chambers delivered four babies in five hours at widely dispersed points in Anderson. All of them were delivered at homes. Few if any of his patients had babies in hospitals in that day.

Dr. Chambers somehow escaped the "horse and buggy" days of medicine. He recalls that his first

rounds were made in a Hupmobile with righthand drive.

He still drives a 1928 Hupmobile, which friends graciously allow him to park in a small lot just off E. Market St. It has almost 1,000,000 miles on it, according to Dr. Chambers, and has survived numerous fender scrapings and other wrecks.

"I don't drive it much, in fact haven't had it out in about three months now," Dr. Chambers remarks. "If anybody wants my services I make them come to me."

In past days a few people called on Dr. Chambers for his services and he has the uncollectable bills to prove it. In two huge ledgers in his small office over Benson Street stores overlooking the Square, Dr. Chambers can count more than \$100,000 in "bad debts," not counting all the actual charity work he did when he knew the patients were unable to pay.

He has delivered more than 700 babies in the past 35 years, treated thousands of patients and spent thousands of hours in the medical service.

His mind is nimble and clear, which attests to the worth of his own ability. Some time ago he suffered a stroke which left him paralyzed in one arm and one side of his face.



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DR. SYMMES HONORED

Dr. T. H. Symmes of St. Matthews was honored last November at the meeting of the Edisto Medical Society. He has been a practicing physician for 50 years, having received his diploma from medical college in 1907.

Dr. Symmes was born at St. George on December 29, 1886. He graduated from medical college before he was 21 and served his internship at Roper Hospital in Charleston as chief of staff.

The new doctor started private practice with two horses and a buggy at Fort Motte in 1908. In 1910 he moved to St. Matthews. Dr. Symmes was the first doctor in Calhoun County to use an automobile and also drove the first car over the old State Road from Charleston to St. Matthews.

During World War I, after a training period at Ft. Oglethorpe, Ga., he served as a medical officer with the first tank corps organized in the U. S. Army. The commanding officer of the outfit was Dwight D. Eisenhower who held the rank of captain at that time.

After leaving the armed forces Dr. Symmes returned to his office in St. Matthews as a general practitioner.

At the end of World War II he restricted his practice to office work so that now he has more time for his grandchildren and his hobbies, golf and his camellia garden.

Dr. Symmes was presented a gift at the meeting.

DEATHS

DR. C. B. WOODS

Dr. Clarendon Barron Woods, physician of Walterboro, S. C. died April 23, 1958 at the Naval Hospital, Charleston, S. C. after a very brief illness.

He was born at Red Bank in Lexington County, S. C. on August 4, 1901.

Dr. Woods graduated from New Brookland High School. He entered the School of Pharmacy of the Medical College of the State of South Carolina in September 1921 and graduated in June 1923 with a Ph. G. degree. He entered the University of South Carolina in the fall of 1923 for his pre-medical work and took in addition enough subjects in pharmacy so that he was graduated in June 1925 with the degree of Pharmaceutical Chemist. He entered the school of medicine of the Medical College of the State of South Carolina in September 1925 and received his M. D. from that institution in June 1929. He interned during his senior year at St. Francis Xavier Infirmary. After graduation he was for 2 years an assistant in the clinical laboratory of the Medical College. He resigned this position to serve an internship at Rocky Mount, N. C. in order to be eligible to take the examination of the Medical Corp. of the U. S. Army. He successfully passed the examination and became a first Lieutenant in the Medical Corps. He served actively in the army for 17 years and during

World War II was commandant of the 185th General Hospital at Taunton, England. He was discharged for disability in 1946, and by this time had the rank of full Colonel. The next two years he served as County Health Officer of Colleton County. He then took a course of one year in Preventive Medicine at the University of North Carolina.

After completing this course he returned to Walterboro and entered the private practice of medicine, in which he continued until his death.

Dr. Woods was a 32nd degree Mason, a member of Theta Kappa Psi medical fraternity and at the time of his death was Chief of Staff of the Colleton County Hospital.

DR. W. B. McWHORTER

Dr. William B. McWhorter, a resident of 207 Calhoun St., and a well known eye, ear, nose and throat specialist, died in Anderson Memorial Hospital. He had been ill for the past several months.

Dr. McWhorter was born in Georgia, but spent most of his adult life in Anderson. He was an honor graduate of the University of Georgia class of 1909, and an honor graduate of the Emory University School of Medicine in 1915.

He was in the U. S. Marine Hospital service from 1915 to 1917, did post graduate work at Cornell University and New York Post Graduate School, 1917 to 1919.

He located in Anderson for the practice of his profession in February of 1919, and later did post graduate work in London, Paris and Vienna for about six months in 1925.

Dr. McWhorter was a devoted member of St. John's Methodist Church of Anderson and also of the local Elks Club. He was a member of the Anderson County Medical Society, the South Carolina Medical Association, the Southern Medical Association, a fellow of the American College of Surgeons, and a fellow of the American Medical Association.

DR. J. B. LATIMER

Dr. Latimer of Anderson died recently. He was born in 1891 and graduated from the Medical College of South Carolina in 1917.

The Anderson papers said of him:

"Referring to Dr. J. B. Latimer as a 'family doctor' of the old school by no means infers that he didn't keep abreast of and practice in his own specialist fields.

"Yet his was a general practice and many Anderson families — from grandfather to youngest grandchild — knew Dr. Latimer as 'our doctor' and appreciated and had faith in his outstanding ability, skill and knowledge.

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to exude the elixir of good cheer no matter what his own burdens of heart and body might be.

"His departure from this world's shores this week leaves hundreds of his patients and other friends keenly feeling the loss. Dr. Latimer will be long remembered as one who, in the highest and best meaning of the term, was a credit to his profession.

"This community would be lesser in health, well-being, and happiness if there had been no Dr. Latimer, and that fact shall stand as an enduring edifice to his memory."

DR. SYLVIA ALLEN

Dr. Sylvia Allen, psychiatrist and native of Charleston, died April 15 after a long illness.

Dr. Allen was born in Charleston Jan. 7, 1892, a daughter of James B. Allen and Mrs. Mary M. Bailey Allen. She attended the schools of Charleston and was graduated from Goucher College, Baltimore.

In the 1920s she received her M. D. degree from the College of Physicians and Surgeons in New York and interned in that city.

She practiced in Charleston for several years, going to Winthrop College as resident physician in 1931. She moved to Charlotte two and a half years later and began a general practice there.

Dr. Allen studied psychiatry at Johns Hopkins in Baltimore in the mid-1930s. After completing her psychiatric studies, she taught at the Menninger Clinic in Topeka, Kan. She continued to lecture there until she became ill.

She moved to Kansas City in 1941 and specialized in psychoanalysis. She also taught at the medical school of the University of Kansas and lectured at medical centers throughout the country.

BOOK REVIEWS

HOSPITAL ACCREDITATION REFERENCES.

American Hospital Association, Chicago, 1957.

This is a compilation and organization of the many various matters bearing on hospital accreditation by the Joint Commission on Accreditation of Hospitals. It should be interesting and useful for all who are concerned with the workings of hospitals. It sets forth clearly the conditions which must be considered in improving hospital affairs for the achievement of accreditation.

J.I.W.

EXPERIMENTAL PSYCHOPATHOLOGY. Edited by Paul H. Hoch, M. D. and Joseph Zubin, Ph. D. Grunc and Stratton, New York—1957. Price \$6.50.

This book contains the proceedings of the 45th Annual Meeting of the American Psychopathological Association. Organized in 1912 with Adolph Meyer as its first president, this association has been headed by men who have made significant contributions to American Psychiatry. Its present membership, listed in the appendix, is short in number but long in accomplishment. The papers in this volume are intended to give a broad view of current psychiatric research. The view is broad indeed, covering as the preface states "the entire gamut from animal to man". We find such titles as "Generalization and Extinction of Experimentally Induced Fear in Cats", "Experimentally Induced Depersonalization", "Perception of Parents and Social Attitudes", "Studies in Human Ecology", "The Problem of Schizophrenia in the Light of Experimental Psychiatry". While no project here reported probably represents in itself a significant milestone in psychiatric progress, as a whole the papers are interesting and bear witness to the intensive and multifarious research that is now going on in the field of psychiatry. But this research is impressive only when we consider the dearth of such in the past. The work done is small and the support given it meager when we consider the size of the problem—as illustrated for instance by the fact that one out of every four hospital beds is presently occupied by a schizophrenic.

Joseph H. Marshall, M. D.

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The Journal

of the

South Carolina Medical Association

VOLUME LIV

July, 1958

NUMBER 7

THE RIGHT OF A PATIENT TO DIE

JOHN J. FARRELL, M. D.
Miami, Florida

Recently, during an inspection of our medical school by an accrediting committee,

I was asked to delineate my concept of a surgeon and my philosophy of the role of surgery in the educational endeavours of a medical school. Well aware that the committee of five men was composed of three internists, a basic scientist and one surgeon, I was still compelled to give an honest answer and said "First of all, a surgeon is an internist who has had additional training. Secondly, in a medical school, the department of surgery should teach what diseases can and cannot, what diseases should and should not, be treated by surgical philosophical principles and then we should teach the students about all the diseases concerned regardless of whether they are best handled medically or surgically. In other words, we believed in teaching general medicine with the added background of surgical philosophy".

Needless to say, this answer met with considerable comment and the ensuing hour was interesting to say the least. I cite this, not to burden you with the problems of medical education but as a half-hearted apology for the topic I have chosen for this evening. At a gala gathering like this, perhaps one's theme should be light and amusing. But I believe sincerely what I said to that committee. Surgery is not

merely a branch of the healing arts; it is philosophy of medicine; if you will, it is a way of life. We cannot be surgeons eight hours a day and something else the remainder of the time. We must eat, live and sleep surgical philosophy. As surgeons, in the proper definition of the term, we are concerned not only with life and death but with the myriad facets, liminal and subliminal, surrounding both life and death.

Because of those facts, I would like to take this opportunity to share with you a problem to which there is no ready answer but a problem which all of us face many times, day in and day out. That problem, simply stated is this: "The right of a patient to die". Please do not misunderstand me, I am *not* discussing euthanasia for which I hold no brief; as Hippocrates has said: "I will use that regimen which according to my ability and judgment shall be for the welfare of the sick, and I will refrain from that which shall be baneful and injurious. If any shall ask of me a drug to produce death, I will not give it, nor will I suggest such council".

In our pursuit of the scientific aspects of medicine, the art of medicine has sometimes unwittingly and unjustifiably suffered. We have, on occasion, been so concerned with the "right of all men to live" that we are in danger of forgetting that it is appointed for all men, once to die.

As surgeons we all too often consider death a personal defeat. Like John Donne, an Eng-

A Banquet Address to The South Carolina Chapter, American College of Surgeons—Greenville, S. C., November 22, 1957.

Dr. Farrell is Professor and Chairman, Department of Surgery, University of Miami School of Medicine, Chief of Surgery, Jackson Memorial Hospital.

lish minister of the 16th Century we feel that: "No man is an island entire of itself, every man is a piece of the continent, a part of the main. If a clod be washed away by the sea, Europe is less, as well as if a promintore were, as well as if a manor of thy friends or of thine own were; any man's death diminishes me because I am involved in mankind, and therefore, never send to know for whom the bell tolls, it tolls for thee".

Yet we must acknowledge that death is inevitable. As a child reading biblical stories, I was much impressed with the dignity of death: a patriarch surrounded by his children and his children's children sorrowing but eager to hear the last wise words of counsel dropping from the dying lips. What troubles me is that as a surgeon I have rarely witnessed such a scene. If a patient has a right to die as well as a right to live, he has a right to dignity in either instance. I submit that the death bed scenes I witness are not particularly dignified. The family is shoved out into the corridor by the physical presence of intravenous stands, suction machines, oxygen tanks and tubes emanating from every natural and several surgically induced orifices. The last words, if the patient has not been comatose for the past forty-eight hours, are lost behind an oxygen mask.

I discuss this, not because I have an answer to the problem but because it is a very real problem which all of us must face. Frequently on the wards of our hospital, my surgical residents come to me actually troubled and concerned. Mr. So and So has widespread metastases and is bleeding, how vigorously should he be treated? What is our proper role as physicians in sustaining life in cases like this? How much or how little therapy is ethically or morally proper? What about his hospital bills? I am inordinately proud of these young men when they raise these questions. At those times I feel confident of the shining future of the surgical profession. If eager young men caught up in the hustle and hurry of a busy surgical service, immersed in the pride and satisfaction of knowledge acquired and techniques perfected pause to consider their role as doctors and humanitarians, then postgraduate surgical

residencies are assured of success. Lately I have been struck by the number of times the same discussion and questions arise in informal meetings with other practicing surgeons. There is no doubt that this awareness and concern is pertinent today. Perhaps some of you have read the January 1957 issue of the *Atlantic Monthly*. In that issue a widow wrote an article entitled "A Way of Dying". The opening lines begin "There is a new way of dying today. It is the slow passage via modern medicine If you are going to die it can prevent you from so doing for a very long time". The *Atlantic Monthly* commenting on the article said that the large metropolitan hospitals have "made dying . . . an ordeal which has somehow deprived death of its dignity".

The New England Journal of Medicine in an editorial comment on the article says "Today's graduate falls heir—and with no extra effort—to the immaculate, modern aseptic skills that can keep a diseased, half-dead, cancerous body alive, by intravenous nourishment and with the magic of penicillin and round-the-clock special nursing, so long that the doctor may emerge in the eyes of the kin with little resemblance to the wise and understanding physician of yesteryear. In that picture known to most physicians the kindly, bearded humanitarian sits quietly by the bedside waiting for his little patient to die or to recover; the decision is not his. There is hidden ignorance and sentimentality in the picture, but there is, paradoxically great strength, beauty and spiritual dignity implicit in the situation portrayed".

The history of medicine is replete with countless examples of the wide swing of the pendulum in medical thought and therapeutic fashions. With the rapid progress of the scientific aspects of medicine, with all the startling new discoveries, ignorance of the latest techniques and practices cannot be tolerated in our enlightened, modern era. The staid old jokes about burying our mistakes no longer elicit a weak smile but merit instead an irritated frown. So the pendulum tends to swing away from the proper balance of the science and art of medicine to a point where

all out, heroic measures embodying all the most recent advances and all the ancillary services must be employed in every instance. I might add that this violent swing of the pendulum is not due to the medical profession alone but has received considerable momentum produced by the lay press and the lay public demanding the employment of our "modern miracles".

As I have said, I do not know the answer. I do not believe there is an easy answer to be found in the entire philosophy of surgery. Surgery implies rapid and correct judgments predicated upon intimate knowledge of the sciences of physiology, biochemistry, pharmacology, bacteriology, pathology and anatomy as well as the proper employment of technical skills. However, it also implies meticulous attention to minute detail, intimate knowledge of and an appreciation for the economic, psychosomatic, social and moral as well as the physiologic and pathologic aspects of humanity. Ethical standards are not ac-

quired by the repetition of a pledge nor is a moral sense developed by osmosis alone on the hospital wards. As continuing students of surgery we must also acquaint ourselves with the discussions of sociologists and philosophers. Each one of us must strike a balance between the science and the art of medicine. We must hold to our Hippocratic oath in the light of present day knowledge and our own spiritual values. Each one of us must constantly ask oneself; wherein lies the glory of a technical triumph which precipitates economic, social or spiritual bankruptcy? We cannot allow culpable ignorance to mask itself in the guise of humanitarianism, neither can we allow scientific achievement to preclude the right to live or the right to die with the dignity which is the right of every man. In the last analysis we must seek guidance beyond ourselves and I for one can only repeat that ancient psalm "Out of the depths I cry to thee O Lord, Lord hear my prayer".

FAT EMBOLISM

D. B. NUNN, M. D. AND F. E. KREDEL, M. D.
Charleston, S. C.

Introduction

THE increasing incidence of trauma associated with the fast-moving conditions of modern life emphasizes the importance of adequate understanding of the proper care and management of patients with traumatic injuries. One of the least understood and more serious complications which may be associated with traumatic injuries is fat embolism. The mortality in clinically diagnosed cases of fat embolism is usually high, but probably can be significantly reduced through better understanding of the problem and its correct management. Accordingly, it is the purpose of this paper to discuss the incidence of fat embolism, to present the more commonly accepted views with regard to pathogenesis and

pathophysiology, to delineate the usual clinical picture, and to elaborate on some of the more promising therapeutic approaches which have been advocated.

Incidence

Although commonly thought of as a rare complication of trauma, fat embolism has been found to occur in a significant number of cases with traumatic injuries encountered in both wartime and civilian practice. During World War II, The Committee for the Study of the Severely Wounded found evidence of fat embolism in the lungs of 65% of 60 cases dying after various types of battle wounds.¹ In the Korean War, fat embolism was reported in 39% of a group of 79 cases dying of battle injuries.² Robb-Smith,³ in civilian practice, has reviewed 789 accident cases in which there were 125 deaths. Forty-one of the pa-

Department of Surgery, Medical College of South Carolina.

tients who died had gross evidence of pulmonary fat embolism which was severe enough in 29 cases to be considered the major cause of death. Musselman et al.⁴ have studied 109 cases with civilian injuries, and found signs and symptoms of fat embolism in 55% of the cases; thirteen deaths were attributed to fat embolism.

Fat embolism usually is associated with traumatic injuries in which there are fractures of the long bones, but is also seen after extensive soft tissue injury alone.⁵ Moreover, it may occur after operative trauma on either bone or soft tissue^{6,7} or both, and has been reported in association with such conditions as osteomyelitis, suppuration of fatty tissues,⁸ diabetes mellitus,⁹ acute pancreatic necrosis,¹⁰ and chronic alcoholism¹¹ without any antecedent history of trauma.

Pathogenesis and Pathophysiology

The pathogenesis of fat embolism is still a matter of considerable controversy. However, the weight of evidence to date seems to favor the direct entrance of fat globules into the venous system at the site of injury as the most common mechanism in cases associated with trauma. Still, this does not explain those cases in which there has been no trauma. It has been recently postulated¹² that such cases may result from a change in the state of emulsification of neutral fat normally present in the serum. However, whether or not this is true has not been definitely determined.

Assuming that fat globules are intravasated into the venous circulation in cases of embolism following trauma, the immediate effect produced is mechanical obstruction of the pulmonary arterioles with resultant acute pulmonary hypertension. In order to compensate for this condition an increased output of the right ventricle is required. With normal circulatory dynamics, allowing for an augmented venous return, the heart is able to compensate for considerable rises in pulmonary arterial pressure. On the other hand, in the presence of hemorrhagic shock associated with fat embolism, death ensues rapidly from acute right ventricular failure unless circulating blood volume is soon restored.

If the patient is able to survive the acute

effects of pulmonary arterial obstruction, a portion of the fat globules is forced through the pulmonary capillary beds into the systemic circulation whence they are once again arrested in terminal arterioles. Systemic embolization to the brain, kidneys, and skin of the upper trunk is particularly common. Unless the degree of systemic embolization is severe enough to produce marked cerebral obstructive symptoms or death, a latent period of 24 to 72 hours follows before the classical signs and symptoms of fat embolism appear. It is now believed that this latent period represents the time interval between lodgment of neutral fat emboli and the hydrolysis of sufficient fatty acids from this fat to produce the local hemorrhagic effects noted on pathological examination. Possibly the elevated serum lipase levels, which have been detected by some investigators^{13,14} during the early stages of fat embolism, may be the crucial factor in initiating this hydrolysis. At any rate, it would appear that the classical signs and symptoms of fat embolism are probably on a chemical basis.

Clinical Picture

The clinical picture of fat embolism may or may not be easily recognized depending on the extent of embolization and associated injuries. Usually the patient is the victim of a severe crushing injury frequently associated with a fracture of a major long bone, such as the femur or tibia. The initial signs and symptoms produced within a few minutes or hours after injury are usually those of pulmonary embolization. Symptoms may be minimal or severe with dyspnea, hyperpnea, cyanosis, and venous distention followed by death. If the patient survives, cerebral obstructive symptoms of restlessness, delirium, or coma may appear depending on the severity of systemic embolization. In some cases, marked cerebral symptoms may present without any premonitory pulmonary signs;¹⁵ however, the possibility of an associated head injury must always be considered.

Characteristically, a free or latent period of 24 to 72 hours follows the acute obstructive phase before classical signs and symptoms of fat embolism develop. Often the patient who

has seemingly been recuperating well from the effects of his injuries, suddenly becomes restless and anxious and may progress to a state of delirium or coma. Various neurological abnormalities may appear, but usually there are no localizing signs since the process of embolization is diffuse. Pulmonary signs suggestive of pneumonia are almost always present, and a chest film at this time shows patchy areas of increased density scattered throughout both lung fields. Body temperature varies from subnormal to hyperpyrexia levels depending on whether or not the heat-regulating center of the brain is disturbed by emboli and the presence or absence of superimposed infection. Petechial hemorrhages commonly appear in the skin of the upper trunk, especially in the axillae and lateral aspect of the chest wall. Although embolization to the kidneys frequently occurs, signs of renal failure usually are not present. However, during the acute phase of embolization, fat globules are occasionally found in urine specimens stained with Sudan III if the topmost layers of urine in the bladder is secured for examination.¹⁶

The clinical diagnosis of fat embolism is usually established on the basis of the clinical picture in combination with a roentgenogram of the chest. Although demonstration of fat droplets in the urine is diagnostic, the test often is not positive.

The differential diagnosis, as previously implied may cause considerable difficulty in certain instances. It may be particularly troublesome to differentiate fat embolism from intracranial bleeding since a free interval followed by progressively deepening coma may occur with both conditions. External evidence of head injury in addition to localizing signs, which usually do not occur with fat embolism, may help in the differentiation. However, it is well to remember that the two conditions, head injury and fat embolism, may coexist, and if any doubt is present, exploratory trephination under local anesthesia should be performed.

In the early stages, fat embolism may also be confused with the syndrome produced by hemorrhagic shock; indeed, it is often associated with hemorrhagic shock after extensive

traumatic injuries. However, symptoms referable to shock alone should disappear within a short period of time after circulating blood volume is restored.

The differentiation of fat embolism from a pulmonary blood clot embolus should cause little difficulty. Pulmonary blood clot embolism rarely occurs before the 10th day after trauma whereas symptoms of fat embolism are almost always seen within 1 to 6 days after injury.

For unexplained reasons, fat embolism seems to have a special predilection for chronic alcoholics with a fatty liver.¹¹ Consequently, cerebral signs of restlessness followed by delirium must be differentiated from delirium tremens.

In cases with prominent pulmonary signs, the clinical picture may initially be confused with bronchopneumonia. However, the appearance of additional signs and symptoms associated with fat embolism should afford sufficient evidence to establish the correct diagnosis.

Treatment

The treatment of fat embolism is for the most part non-specific. However, it is of definitive benefit since there are many features in the correct management of patients with traumatic injuries which will diminish the danger of fatal fat embolism.

Preventive treatment is of prime importance. The early, effective splinting of fractures and careful handling of the patient are factors that have been definitely shown to decrease the incidence of fat embolism. Elevation of the injured extremity has also been suggested since it may be of benefit in decreasing the amount of fat entering the general circulation.¹⁷ The use of a pneumatic tourniquet has been recommended for all elective operative procedures on bones of the extremities.¹⁸ This has been shown to decrease the amount of fat reaching the lungs if the tourniquet is not removed until the limb has been immobilized in a splint or dressing.

The most important feature in the treatment of the mechanical obstructive phase of fat embolism is the prevention of shock. If shock is present, it should be treated en-

thusiastically with oxygen and adequate blood replacement.

Rapid digitalization has been recommended¹⁹ during the obstructive phase in cases in which signs of early heart failure can be detected. Probably this is worth a trial although the true effectiveness has not been definitely determined.

Several measures have been tried in an attempt to disperse the fat globules into a finer emulsion in order to relieve the obstructive effect of embolization. Hermann²⁰ has recommended the use of intravenous infusion of 5% dextrose and 5% ethyl alcohol; the suggested therapeutic dose of 95% ethyl alcohol ranges between 0.5-1.5 ml/kg. of body weight. Alcohol has the additional advantages of relieving pain and providing sedation without respiratory depression. The authors²¹ have recently become interested in the use of intravenous Decholin, a derivative of a bile acid which has both vasodilator and emulsifying properties. The preferred dosage of Decholin is not known, but it may be given safely in doses of 5 ml. of a 20% solution 3 or 4 times daily since the effects of the drug are transient and side reactions are uncommon. Although the value of these measures is unsettled, it is felt that they warrant further clinical trial. Heparin has also been used in an attempt to disperse fat emboli, but is probably contraindicated since one of the end products of the reaction between lipoprotein lipase and neutral fat is free fatty acids.

The specific treatment of the chemical phase of fat embolism, in the patient with the classical signs and symptoms, remains an unsolved problem. Suggested approaches⁵ to this problem have been: 1). the use of an agent to suppress the release of serum lipase during the early stages of fat embolism and 2). intravenous infusion of calcium ions during the chemical phase in an attempt to immobilize free fatty acids as soaps.

Summary

One of the least understood complications of trauma, fat embolism, occurs in a significant number of cases, and may be associated with a high mortality rate. It usually follows those

injuries in which there are fractures of the long bones, but may also occur after extensive soft tissue injury alone.

The concept of direct entrance of fat globules into the venous system at the site of injury is generally accepted. Initial symptoms, usually those of pulmonary embolization, may occur within a short time after injury and are usually followed by a latent period of 24 to 72 hours before classical signs and symptoms develop.

Clinical diagnosis is usually established on the basis of the clinical picture in combination with a chest roentgenogram. Fat droplets in the urine are diagnostic, but often are not detected.

The treatment of fat embolism is largely non-specific, but is definitely worthwhile. Preventive treatment though adequate splinting, careful handling of the injured patient, and prevention of shock is of prime importance.

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HYPERTHYROIDISM A CURRENT VIEW

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Recent advances in our knowledge of the thyroid gland, including the purification of the thyroid hormone, have permitted the unqualified declaration that hyperthyroidism is the result of an excessive release of normal thyroid hormone.

The exact mechanism for the synthesis of the thyroid hormone within the gland is not yet fully established. It is known that iodine is needed in the synthesis of thyroxine by the thyroid gland and that the gland stores this iodine in the form of iodide in a concentration some twenty-five times greater than that of the blood.⁶ The iodide is converted to iodine by a high energy oxidation reaction which is catalysed by a peroxidase enzyme. The free iodine, thus liberated, is used in the iodination of tyrosine to form iodotyrosine. Two of these iodotyrosine molecules are then combined to form diiodotyrosine which in turn is combined with a globulin to form thyro-globulin, the active principal of the thyroid gland.⁶

It has been known for some time that the thyroid gland is under the control of a thyroid stimulating hormone produced in the anterior lobe of the pituitary gland. It has recently been established that this thyroid stimulating hormone is elaborated by the basophilic cells of the anterior lobe of the pituitary. This work is mainly accredited to Dr. Peter Heinbecker³ of St. Louis who, through numerous investigative studies, has shown that the basophilic cells of the anterior pituitary are trophic not only to the thyroid gland but to the ovaries and to the testicles. His various and numerous experiments have also shown that there is a

definite relationship between the posterior pituitary or neural hypophysis, and the basophilic cells due to hormones elaborated within the posterior pituitary. He has, further, shown that the posterior pituitary is, in turn, under the influence of two paired nuclei in the hypothalamus, the paraventricular and supra-optic nuclei.

To sum up then, it has been fairly well established that paired nuclei in the hypothalamus, when stimulated, are trophic to the secretion of certain hormones in the neurohypophysis, which hormones produce changes in the glandular hypophysis, namely an increase in the basophilic cells. These cells then produce a thyrotrophic hormone whose action regulates the amount of thyroxine produced in the thyroid gland.

Consistent with the implications that excitation of these nuclei, rather than depression, results in hyperthyroidism is the evidence that associated with this disorder there is invariably evidence of increased activity of the sympathetic and parasympathetic systems, portions of whose centers are located in the hypothalamus. The clinical manifestations of such increased activity is well known. In contrast, depression of activity in these paired nuclei in the hypothalamus has been shown to lead to diastolic hypertension, diabetes mellitus, arterio-sclerosis and obesity. Persons exhibiting diastolic hypertension, known to be due to depression of these nuclei, show no increased activity of the sympathetic or parasympathetic systems.

There are essentially two types of hyperthyroidism. There is that type which is ini-

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tiated in the central nervous system as described above. This is the Graves type and is associated with exophthalmus. In this type, the thyroid gland is diffusely stimulated and enlarged. The other type is due to a condition primarily local in the thyroid gland. It is exemplified by the actively secreting adenoma.³ This adenomatous tissue has, for some unaccountable reason, an increased susceptibility to the thyroid stimulating hormone. What the local change in the thyroid cell is to cause this susceptibility is not known.

Until recent years the basal metabolic rate determination has probably been the most widely employed laboratory test for the determination of hyperthyroidism. This test today is infrequently employed as a serious determination of the existence of hyperthyroidism.⁴ An increase in the measured rate of basal oxygen consumption is observed in so many other conditions that its value in the determination of hyperthyroidism is minimal.

There are those who feel that the serum cholesterol concentration is a valuable diagnostic aid. The majority feel, however, that its greatest usefulness is in following the efficacy of one's therapy in the hyperthyroid patient.

The serum protein-bound iodine determination, the P.B.I. which represents the circulating thyroxin concentration, is perhaps the most reliable index to the presence and course of thyroid disease. Normal values of PBI are between 4 and 8 gamma per cent (micrograms per 100 ml of serum) except in pregnancy where the range of values obtained without evidence of thyroid disease is 6 to 10 gamma per cent.¹ This determination requires a rather meticulous technique. It is, however, within the capacity of many hospital laboratories.

The increased production of thyroxin in hyperthyroid patients is reflected by an increase in the capacity of the thyroid gland to take up radioiodine. This fact has led to a very important diagnostic procedure. It consists of administering a small oral dose of radioactive iodine (I^{131}) and then measuring the accumulation in the thyroid gland with a Geiger-Müller counter. In the normal euthyroid individual the thyroid uptake of I^{131} , with-

in a twenty-four hour range, is between 10 and 50% of the tracer dose. In hyperthyroidism, the uptake is between 50 and 100% and, for the most part, is usually over 90%. In myxedema, the uptake is less than 10% of the tracer dose. There is occasionally some overlapping in these ranges of the clinical groups, but in general the test is highly specific and diagnostic.

The treatment of hyperthyroidism has also made great strides, particularly since the advent of the anti-thyroid drugs, which were first reported on by Astwood in 1943.² Since that time, various refinements have been made in the drugs and today the two most popular are propylthiouracil and tapazol. These two drugs have been shown to offer the highest efficiency with the least toxicity. Their mode of action is not exactly known but it is felt that they work in one of two ways. They either inhibit the peroxidase enzyme system, thereby holding down the conversion of iodide to free iodine or they act by binding with the free iodine elaborated in the acinar cells so that hormone synthesis cannot occur. The extent to which hormone synthesis is reduced seems to be dependent on the dose of the drug and the frequency with which it is given.¹ It has been pretty well established the drug should be given at no later than eight hour intervals. Aside from the dosage and the regularity of administration, the time necessary to effectively produce a reversion to the euthyroid state depends upon the amount of stored colloid in the gland. It would seem that these anti-thyroid drugs have no effect on the thyroxin which had already been produced and stored.² The good results of therapy must, therefore, await the utilization of this stored colloid. Because of the suppression of the production of thyroxin in the thyroid gland, there is some hypertrophy and hyperplasia of the basophilic cells of the anterior pituitary which, through an increase in the thyrotropic hormone, produce considerable hyperplasia of the thyroid gland.⁶ Therefore, one should not be alarmed if during the course of anti-thyroid therapy the gland is noted to enlarge.

There has, as yet, been no failure of treatment recorded in the literature.² That is to

say, anyone who has been treated with a sufficient dosage of anti-thyroid drug with regularity and over a sufficient period of time will eventually become euthyroid. It might be said then, that the anti-thyroid drugs work in 100% of cases. The main problem arises only after the patient has become euthyroid. If the anti-thyroid drug is stopped at this point, hyperthyroidism will recur in almost 100% of cases. If the drug is continued as a maintenance dose for a period of 18 months to 2 years and then discontinued, approximately 30 to 50% of patients will have a recurrence of the hyperthyroidism.⁴ Maintaining the drug therapy beyond this point seems to have no beneficial influence on the recurrence rate. It can be seen then, that these drugs are not the complete answer to the therapy of hyperthyroidism and, actually, have been relegated to a position of preoperative therapy. There is, at the present time, very little excuse for operating upon an individual with hyperthyroidism who has not been rendered euthyroid by the administration of the anti-thyroid drugs.

Agranulocytosis is almost unknown as a complication. Leukopenia, however, does occur and purpura is occasionally seen. For the most part, however, these anti-thyroid drugs are so effective in practice and so free from toxicity, that if the patient is available to the physician and is warned to report any rash, fever, or sore throat, there is virtually no danger.

Another highly efficacious method of treatment of hyperthyroidism which has been used since 1940, is radioactive iodine therapy. A dose is delivered to the thyroid gland which actually causes necrosis of the cells that absorb it. Grossly, the effect of treatment is to shrink the thyroid gland down to approximately normal size. The dosage is calculated on the basis of the size of the gland which must be estimated in grams. It is necessary to know, also, the amount of the I^{131} which the gland will take up. This is determined by giving a tracer dose and monitoring with a Geiger-Müller counter at six and twenty-four hours, with the higher of these two radioactivities taken as the maximum uptake. The

final factor which must be known is the effective half life of the iodine which has been taken up. This is determined by measuring with the counter until such time as only 50% of the maximum level taken up remains.

The incidence of side effects is minimal and one has, actually, a subtotal thyroidectomy without surgery. One, of course, must ask why is this treatment not universally accepted for hyperthyroidism. The answer lies in the fact that no one is quite sure what will happen to this irradiated gland. It is felt that, if the patient lives long enough, he may very well develop a carcinoma of the thyroid on the basis of radiation burn. Since radioactive iodine has only been in use since 1940, there are not enough long term follow-ups to answer this question adequately.⁶ The radioactive iodine therapy of hyperthyroidism is, therefore, relegated to those individuals with hyperthyroidism whose life expectancy is not over 15 to 20 years, or who have some coexistent disease which may limit the life expectancy.⁴

Should the patient fall into the above categories but have a nodular goiter with hyperthyroidism, radioactive iodine is not necessarily the treatment of choice.⁶ The reason is, of course, that the radioactive iodine therapy will do nothing to remove these nodules and may, actually, accentuate them, which is, of course, unsightly. Of more importance is the fact that one cannot tell whether any of these nodules represents a true tumor or merely a hyperplastic-involutated nodule.

It is concluded then, that at the present time the treatment of choice of hyperthyroidism, for the majority of patients, is radical subtotal thyroidectomy. Prior to surgery, the anti-thyroid drug should be used in order to render the patient euthyroid and then, approximately two weeks prior to surgery, iodine therapy should be administered to produce involution of the markedly hyperplastic and vascular gland. Radioactive iodine therapy should be reserved for those individuals with a diffuse toxic goiter whose life expectancy is no greater than 15 to 20 years.⁵

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PRELIMINARY TRIALS WITH TWO NEW COMBINATIONS OF DERMATOLOGIC AGENTS

NYSTATIN, ANTIBACTERIAL, FLUDROCORTISONE OINTMENT AND TAR, QUINOLIN, FLUDROCORTISONE OINTMENT—A STUDY OF THEIR USE

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Our experience has shown that many common dermatological problems are caused or complicated by mixed bacterial and fungal infections. The successful treatment of these conditions depends on the selection of a therapeutic agent to which the micro-organisms present in the lesion are sensitive. The combination of an anti-inflammatory drug with agents capable of attacking fungi as well as bacteria, in a single topical preparation, suggests itself as a simple approach to this type of problem. In the present report, the use of two ointments, each consisting of several drugs widely accepted by dermatologists, is described. These two preparations were given preliminary trials in patients with various infectious skin diseases encountered in our private practice. The results of these trials are herein evaluated.

Materials and Methods

The ointments* were designated as follows: Mycostatin-Florinef-S ointment* and Florinef with Tarquinor ointment. The Mycostatin-Florinef-S ointment contained per gram of ointment base:

fludrocortisone acetate	0.1%
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neomycin	0.25%
gramicidin	0.025%
nystatin	100,000 units

In this preparation, the anti-inflammatory activity of fludrocortisone, shown by others¹⁻⁴ to be at least 10 times that of its parent compound, is supplemented by the established topical antibacterial activity of neomycin and gramicidin, and by nystatin, a well known antifungal agent particularly effective against cutaneous candidal infections.⁵⁻¹¹

The Florinef with Tarquinor ointment contained:

crude coal tar (low carbon content)	1.0%
fludrocortisone acetate	0.1%
chlor-hydroxy-quinolin	0.2%

In this preparation, the anti-inflammatory effect of fludrocortisone is abetted by the anti-pruritic action of crude coal tar¹²⁻¹⁷ which also provides considerable keratogenetic action. Chlorhydroxyquinolin is a strong antiseptic.

Mycostatin-Florinef-S, was employed over a period of 18 months in the treatment of 176 patients (see Table 1). The ointment was applied sparingly over the affected areas two to four times daily for a period of one to several days. Patients were instructed not to rub the ointment into the skin.

Florinef with Tarquinor ointment was administered to 19 patients in a dosage regimen similar to that described for Mycostatin-

*Supplied through the courtesy of the Squibb Institute for Medical Research, New Brunswick, New Jersey.

*Since this manuscript was submitted, the mycostatin-Florinef-S ointment has been put on the market under the name Myconeef.

Florinef-S ointment (see Table II.)

Results

Of the 176 patients receiving Mycostatin-Florinef-S ointment, 168 obtained good or excellent therapeutic results. There was no evidence of toxicity. The ointment was exceptionally valuable in cases of intertrigo, hand eczema, paronychia, seborrheic dermatitis complicated by secondary infection, and so-called "diaper rash."

Of the 19 patients given Florinef with Tarquinor, good or excellent clinical effects were seen in seventeen cases. One patient exhibited local irritation on exposure to sunlight, possibly related to a photo-sensitizing action of the coal tar, but this patient continued to apply the medication with good effect. Another patient requested that the drug be discontinued because of burning sensations associated with its application. No patch tests could be made in this case.

TABLE I

Clinical results obtained with Mycostatin-Florinef-S Ointment

Diagnosis	Therapeutic Results		
	Number of Patients	Good or Excellent	Poor
Contact dermatitis	14	14	--
Seborrheic dermatitis	15	14	1
Housewife's eczema	25	22	3
Neurodermatitis	4	4	--
Dyshidrosis, complicated	3	3	--
Paronychia	30	30	--
Folliculitis	2	2	--
Tinea cruris, pedis	2	2	--
Balanitis	12	11	1
Varicose ulcer	1	1	--
Sunburn (infected)	1	1	--
Perleche stomatitis	15	15	--
Intertrigo	31	31	--
Atopic dermatitis	10	10	--
Nonspecific dermatitis	11	8	3
Totals	176	168	8

Comments

In several instances, Mycostatin-Florinef-S was found to be effective in cases where an ointment identical except for the omission of nystatin did not succeed, a fact suggesting the possibility of candidal or dermatophytic infection. In such cases, although scrapings were prepared and examined in potassium hydroxide, candida albicans was only rarely found.

TABLE II

Clinical Data Obtained with the use of Florinef with Tarquinor Ointment

Diagnosis	No. of Patients	Therapeutic Results		
		Excellent to Good	Fair	Poor
Psoriasis	5	4	1	--
Contact dermatitis	3	3	--	--
Neurodermatitis	3	3	--	--
Aene rosacea	2	2	--	--
Dyshidrosis	1	1	--	--
Nonspecific eczema	1	1	--	--
Fungus infection	1	1	--	--
Stasis dermatitis	1	1	--	--
Housewife's eczema	1	1	--	--
Ulcer	1	--	--	1°
Totals	19	17	1	1

°Ointment discontinued because of burning.

On the other hand, in chronic problems often associated with candidal infections, *e. g.*, chronic paronychia, the results obtained with an ointment containing nystatin alone were frequently inferior to those obtained using Mycostatin-Florinef-S, suggesting a primary or concomitant bacterial infection in such cases.

Florinef with Tarquinor was most useful in treating nummular eczema, psoriasis (particularly pruritic anal and pubic patches) and hand eczema. Atopic dermatitis and neurodermatitis were found to respond particularly well when the ointment was administered after the acute and infectious phases of these conditions had subsided.

Summary

1. Two new dermatologic preparations, Mycostatin-Florinef-S ointment, and Florinef with Tarquinor ointment, received preliminary clinical trials in a series of patients with various cutaneous conditions encountered in our private practice. Of 176 patients receiving the preparation containing Mycostatin and Florinef-S, 168 patients manifested good to excellent response. Of 19 patients receiving the Florinef-Tarquinor preparation, good to excellent results were observed in 17 cases.

2. At no time was any evidence of systemic effects due to percutaneous absorption of fludrocortisone noted by clinical or historical observation.

3. It is the impression of the authors that the two preparations employed in this study

are valuable dermatological agents. The Mycostatin-Florinef-S ointment in particular seems superior to the other preparations hitherto available.

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LIMITATIONS IN THE CHEMICAL TREATMENT OF MYELOID LEUKEMIA

A STUDY OF 3926 CASES

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The leukemias are among the most responsive of all neoplastic diseases to chemotherapy.^{21,22} A search of the literature since 1949 discloses that more than four thousand patients with chronic and acute myelocytic leukemia have been treated with chemicals. The 3926 cases listed in Table I do not include those described in 54 articles which failed to state the number undergoing chemotherapy. Many references also do not tabulate the number responding to the treatments. The remission rates given for the most frequently employed chemical agents in Table I were calculated from reports which gave both the number treated and the number responding.

The incompleteness of the published records is not the most serious limitation to the chemotherapy of myeloid leukemia. The lack of ob-

jective standards makes it even more difficult to evaluate the results. The clinical reports come from scores of medical centers throughout the world, and the results which one group of investigators consider satisfactory may be classed as an unsatisfactory response by another. Some reports are supported with detailed laboratory and clinical findings, while others describe only subjective reactions of patients or general impressions of the therapy.

Toxicity and instances of where the action of the drug was contraindicated will be noted under the individual chemicals.

Myleran. Myleran has been the agent of first choice in the treatment of myelocytic leukemia by a number of investigators,^{1,4,7,23,27} and there have been few complaints of serious toxicity. Bohinjec,⁶ however, reported the chemical hastened the downhill course of two of his six patients, and Hayhoe¹¹ had two pa-

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TABLE I
Chemical Management of Myelocytic Leukemia

Chemicals	Number of Cases			No. of References	Remission Rates	
	Total	Chronic	Acute		Chronic	Acute
Myleran	652	630	10	63	50%	10%
N-mustard	610	543	26	91	84%	54%
P ³²	593	563	27	38	55%	4%
Urethan	522	432	17	64	73%	64%
Cortisone—ACTH-FAA	487	139	326	112	66%	53%
Miscellaneous	431	324	111	108	85%	40%
TEM	335	290	44	60	70%	36%
6-MP	291	156	126	32	82%	46%

tients develop bone marrow failure on myleran therapy.

Nitrogen Mustard. Nitrogen mustard shows the highest remission rate in chronic myeloid leukemia in Table I, but Ariens,¹ Bernard,⁴ and Schulten²³ rate it low in chronic cases, and Brimi⁷ and Wintrobe²⁷ reported the drug hastened the course of the disease in acute cases. The toxic action has been noted by several.^{16, 26}

Radiophosphorus. P³² therapy of myeloid leukemia has not met the success of the drug in polycythemia vera. The isotope has shown contraindicated action,^{7, 13, 27} and sometimes it transforms chronic myeloid leukemia into the acute form.¹⁵ Knyazeva¹⁴ described reticulo sarcomatosis in a patient on x-ray and radiophosphorus therapy.

Urethan. Libansky¹⁷ warns of the danger of urethan therapy in turning chronic myeloid leukemia into a terminal acute phase. Evans¹⁰ has raised the question if a primary carcinoma of the liver could be related to prolonged urethan therapy of leukemia. Balestrieri² noted the toxicity of the drug.

Cortisone-ACTH-FAA. These three agents, either separately or in combination, have received the largest number of investigations in Table I (112 references), and also the most complaints. The course of both chronic and acute myelocytic leukemias have been hastened by these agents.^{5, 7, 25, 27} Maness¹⁸ concluded that folic acid antagonist (FAA) therapy was not justified in acute leukemia, and Marchal¹⁹ proposed to abandon Cortisone-ACTH therapy after six cases of Hodgkin's disease and two of myeloid leukemia developed terminal tuberculosis. Berman³ described good hematological remissions with FAA, but he encountered severe toxicity in the therapy. Isaacs¹² noted the development

of pernicious anemia in one patient on FAA therapy.

TEM. Brimi⁷ and Wintrobe²⁷ both warn of the contraindicated action of triethylenc melamine in acute leukemia. Brugsch⁸ noted the appearance of mitosis in the blood during TEM therapy, and Ceresa⁹ warns of the drug's action in myeloid leukemia. Slipyan²⁴ reported fatal bone marrow depression following TEM administration.

6-MP. 6-Mercaptopurine has not been used as extensively as the foregoing chemicals, but it is effective in both chronic and acute myelocytic leukemia, and it is free from some of the limitations noted with other antileukemic agents.

Miscellaneous Chemicals. More than a score of different chemicals have been tested in the 108 publications grouped under this heading. Ariens¹ favors radiogold and arsenic among miscellaneous agents, while Schulten²³ recommends arsenic and thiophosphoramides. Our survey shows 84 remissions in 106 cases (7 acute, 92 chronic) treated with colchicines, 67 remissions in 76 cases (all chronic) on Au¹⁹⁸ therapy, 9 remissions in 11 cases (6 acute, 5 chronic) on As⁷⁶ therapy, 15 remissions in 22 (all chronic) on phosphoramides, and 18 of 19 (14 acute, 4 chronic) on antibiotics. Such preliminary results have no statistical value, but they do warrant further clinical trials.

Acknowledgments. The original literature has been made available by the National Library of Medicine, and the libraries of Furman University and the Greenville General Hospital.

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MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Atrial Fibrillation (and old anterior myocardial infarction)

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Department of Medicine

Case Record—A 60 year old man was admitted to the hospital for treatment of congestive heart failure. According to his referring physician, atrial fibrillation had been present for at least five years, during which time the patient had experienced two attacks of acute myocardial infarction followed by a decreasing cardiac reserve requiring digitalis and diuretic therapy. He had continued to work as a mill superintendent until completely disabled by dyspnea and orthopnea a few days prior to admission. Additionally there was a history of hypertension in middle life and a high familial incidence of coronary disease.

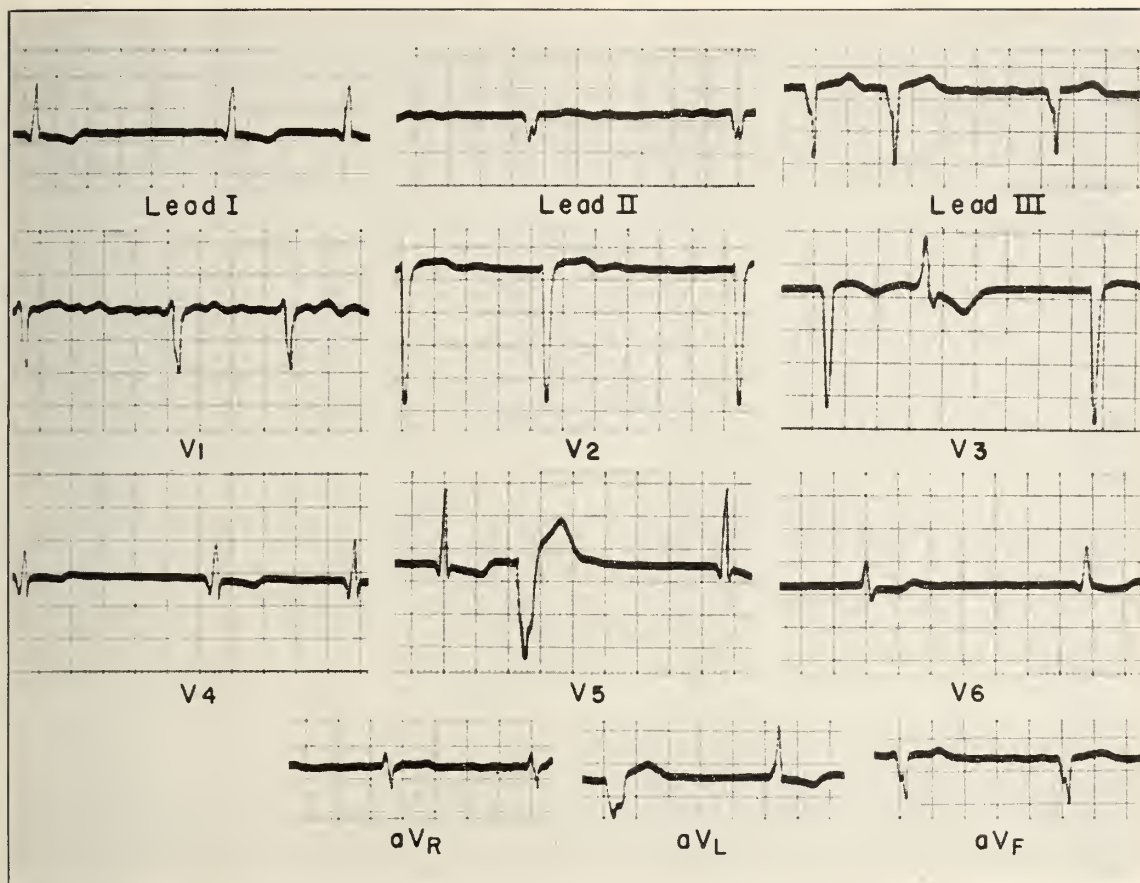
The physical findings were those of advanced congestive failure: distention of the neck veins and of the liver which was felt 4 finger-breadths below the right costal margin, dependent pitting edema, moist rales throughout both lung fields, a diffuse apical impulse in the 6th intercostal space at the anterior axillary line, and a rapid and totally irregular cardiac rhythm. Moderate narrowing and sclerosis of the retinal arterioles suggested a pre-existent hypertension but the blood pressure was normal. A chest roentgenogram revealed gross cardiac enlargement, predominantly of the left ventricular segment, and pulmonary congestion with bilateral pleural effusion.

In the laboratory examinations, which included blood proteins and urea nitrogen, there was nothing of note other than an albuminuria (4 plus) with casts in initial specimens which was not present in the urinalyses following treatment.

As so often occurs in these cases, the rest and intensive treatment in the hospital with measured restriction of the sodium in the diet produced a marked clinical improvement. Diuresis with a weight loss of 16 pounds accompanied the restoration of cardiac compensation. Illustrated here is an electrocardiogram recorded on the ninth hospital day, at about the time of discharge, following administration of increased dosage of digitalis to the level of toxic symptoms. It is similar to one made on a follow-up examination one year later.

Electrocardiogram—The only indication of atrial activity is a rapid and irregular undulation of the baseline evident in V_1 and, to a lesser extent, in leads II and III. There are no discrete P waves. The ventricular rhythm is completely irregular; its rate as measured by the R-R intervals ranges from 44 to 120, with an average of about 65 beats per minute.

Three of the QRS complexes are conspicuously wide and notched, denoting ventricular ectopic beats. The remainder have a normal width of 0.08 sec. and their axis is deviated to the left as shown by the entirely upright deflection in aV1 and the downward one in aVf. Significant Q waves are present in leads I, V_4 , 5 and 6 which, with the absence of R waves in V_3 and the small R of V_1 , are indicative of previous infarction of the anterior wall. That the posterolateral wall also may have been similarly involved is suggested by the simple QS deflections in leads II, III and aVf with



the diminished R of V_6 . In the latter lead it is the complex on the right which is the normally conducted one and this shows a delayed intrinsicoid deflection.

Throughout the tracing are ST and T wave changes consistent with digitalis effect, best noted in leads from the left side of the heart where the T waves are in a direction opposite to that of the main QRS deflections.

(The precordial leads were recorded at one-half the usual sensitivity because of the high amplitude of the deflections.)

Discussion—Atrial fibrillation is characterized electrocardiographically by the absence of P waves, their replacement by rapid and irregular undulations of the baseline, and a completely irregular ventricular response. Instead of undergoing normal activation and contraction the atria remain dilated in a state of chaotic and disorganized activity which is recorded as small irregular waves varying in size, shape and spacing, having an apparent rate on the order of 350 to 550 per minute. These so-called "F waves" are usually best inscribed in precordial leads obtained over the atria but are sometimes indistinct or obscured. The ventricles continue to be activated along their normal conduction pathways so that configuration of the QRS and T wave complexes is usually not

appreciably altered by the arrhythmia, although some slight aberration in these deflections is not uncommon. Very rapid undulations give a fine waviness to the baseline, whereas slower ones such as seen in V_1 of this tracing suggest a *coarse fibrillation*. Occasionally these may become rhythmic enough to simulate flutter waves and are then designated as "impure flutter" or "flutter-fibrillation".

The actual mechanism of atrial fibrillation is as yet not completely understood. One theory postulates innumerable circus type excitation waves occurring in many isolated areas of the atria at once, perhaps perpetuated by the syncytial nature of the myocardium. Another concept views the chaotic atrial activity as the result of rapid ectopic focal discharges occurring at rates too high to permit unified activation of the muscle—essentially, a stage beyond atrial tachycardia and flutter. In either case, stimuli are thought to reach the AV node at far higher rates than the node or the ventricles can accept. Probably only the strongest of these stimuli get through, and then only those which arrive at a time when the node is not refractory. Hence the ventricular rhythm is completely irregular with a rate only a fraction of that of the stimuli which constantly bombard the atrio-ventricular node from above. But just why such a

situation should not provoke a continuous rapid ventricular response at the maximum rate the node could support—why the rate of the ventricles in atrial fibrillation is almost always lower than it is in atrial tachycardia or flutter—has not been satisfactorily explained. Seldom does the average rate exceed 150 (although rarely it may reach 200) and commonly it is within the normal range for pulse rate.

The mechanical phenomena resulting from atrial fibrillation render it a bedside diagnosis. As contrasted to sinus arrhythmia or bigeminal rhythm in which the pulse irregularity occurs in a repetitive sequence, atrial fibrillation produces an "irregular irregularity". There is no consistent pattern in the intervals between QRS complexes. Ventricular filling, and consequently stroke output, tends to vary from beat to beat, so much so that the pulse waves of some contractions are imperceptible in the peripheral artery, causing the well known "pulse deficit" characteristic of atrial fibrillation. Particularly with the more rapid rates of ventricular response the heart rate by auscultation may greatly exceed that which can be counted in the peripheral pulse. Furthermore the first heart sound can often be heard to vary in intensity. Some contractions may follow others by so short an interval that the stroke output is insufficient to open the semilunar valves at all, and on such beats no second heart sound occurs. This irregularity in force, as well as timing of beats, is readily detected in the ordinary blood pressure determination where there is no single systolic reading for all beats, some coming in at higher levels with more beats being heard as the pressure falls. It might be more accurate to express such systolic pressures in terms of a range rather than a single figure. And perhaps the same should be said as regards the rate. All these irregularities in timing, in force of the pulse beat, and in the heart sounds become more obvious at the faster heart rates where one beat falls more closely upon another. This principle is often utilized by the clinician in differentiating a sinus rhythm with many premature contractions or a marked sinus arrhythmia from slow atrial fibrillation—the rhythm of the first two tends to become more regular after exercise whereas irregularity of the latter becomes accentuated.

The three common causes of atrial fibrillation are coronary sclerosis, rheumatic heart disease (especially with mitral valve involvement in which distention of the left atrium itself is thought to be instrumental in producing the arrhythmia), and hyperthyroidism. Nearly all instances of it are attributable to one of these three. Occasionally it may arise from hypertension, from bacterial endocarditis, cor pulmonale, or a severe febrile illness in which there is some component of myocarditis. Rarely the arrhythmia is observed in seemingly normal hearts following exertion

or overstimulation. Atrial fibrillation may be paroxysmal lasting minutes or hours, but in the usual case it goes on for years uninterrupted. If the ventricular rate is slow the patient may be totally unaware of any cardiac disorder, but if rapid considerable circulatory impairment may result. In older patients the fibrillation may appear intermittently before it sets in as a permanent arrhythmia, frequently at ventricular rates high enough to cause angina or frank congestive heart failure. Digitalis has its most dramatic effectiveness in these cases.

The choice between digitalis and quinidine in the treatment of atrial fibrillation is still a matter of some debate. On the one side are those who contend that the actions of quinidine in depressing myocardial irritability and prolonging the refractory period should be tried in all cases to abolish fibrillation and restore a sinus rhythm, thereby restoring atrial function, controlling the heart rate by its normal mechanism, and eliminating the constant threat of formation of mural thrombi in the atria. On the other side are those who point out that quinidine alone may produce an atrial flutter with a dangerously high ventricular rate before it restores a sinus rhythm, and that digitalis by virtue of its action in increasing the block at the AV node effectively lowers the rate of ventricular response, controls it at a safe level even for many years, and offers an additional protection against congestive failure. Furthermore, patients with long-standing fibrillation are notoriously refractory to attempts to restore or maintain a sinus rhythm. Indeed, many of them feel no better if this is accomplished and a few of them (particularly some with advanced mitral stenosis or angina pectoris) seem to be made worse. Unfortunately the abrupt transition from fibrillation to normal atrial contractions is still accompanied in a small percentage of cases by dislodgement of atrial thrombi producing emboli in the pulmonary or systemic circulation, though the risk of this complication may be minimized by prior administration of anticoagulants. Treatment must of course be individualized but probably the most accepted course today is that of digitalization followed by a trial of quinidine unless the patient has an idiosyncrasy to the drug or unless the fibrillation is known to be of many years standing or refractory. Failure of adequate doses of digitalis to slow the ventricular rate should always suggest hyperthyroidism or some acute myocarditis such as rheumatic fever as the cause for the fibrillation. One does not "fibrillate a little less" on treatment—it is only that the pulse deficit decreases as the ventricular rate slows.

The electrocardiogram attains its most authoritative position in diagnosis of the arrhythmias where it portrays the inner workings of the disordered cardiac function.



PRESIDENT'S PAGE

A physician should practice a method of healing founded on a scientific basis, and he should not voluntarily associate professionally with anyone who violates this principle.

In former years physicians concerned themselves mainly with the scientific facet of medicine, displaying little or no interest in Public Relations. Consequently many quacks and nostrums appeared along with various pressure groups and other semi-professional organizations that have been vitally concerned with discrediting organized medicine in the public eye. During this period the quacks prescribed phony nostrums and dangerous treatments on an unsuspecting public poorly informed about scientific methods of medical practice. The pressure groups were very aggressive in our state and national governments, advocating socialization of medicine. And the semi-professional organizations have been trying to emerge into fields of practice far beyond that for which their extremely limited training provides.

During the past few years organized medicine has awakened to the fact that it would have to enter the field of public relations with all the vigor and energy possible. With this in mind, public relations departments were established in National, State, and County Societies, and the A. M. A. set up a Washington office to screen national legislation affecting medical practice, disseminating all the information they could to the profession, making it possible to combat adverse legislation on a grass roots level.

Our interest in the public relations and legislative fields has recently aided tremendously in bringing national and state legislative campaigns to successful conclusions. Work at the grass roots level was extremely valuable in our legislative battle against naturopathy and will certainly have to be called upon again to combat legislation sponsored by other semi-professional groups designed to permit them to perform services that they are extremely lacking in training and knowledge to execute.

Please let me urge every physician in the State to familiarize himself with the Forand Bill and do all the work he possibly can at the local level to inform the layman, Congressmen, and Senators about the dangers of this bill and its backdoor approach to the socialization of medicine. The kindly doctor who treats his patients with intelligent consideration is the best public relations man we know and can individually do a magnificent job in safeguarding the free enterprise system in our country.

R. L. Crawford, M. D.

President, South Carolina Medical Association

Editorials

DAY HOSPITALS AND SPECIAL SERVICES

The great cost of keeping patients in hospitals has caused much thought about ways of reducing expense, with the result that the day hospital has been proposed as a partial solution of the problem. Particularly has the thought of cost and policy been urgent in respect to patients with mental illness, many of whom appear to do better at home than in a continuous stay in hospitals.

In Roxbury, Massachusetts, there has been established an actively functioning day hospital for patients with emotional disturbances. These patients remain in the hospital from 9 A. M. to 4 P. M. and then return home. This arrangement has appeared to prove very satisfactory and results of treatment are thought to be better than in the regular hospitals.

Another facet of the cost problem has been considered in other hospitals by a reduction of certain facilities and a concentration of special services such as the postanesthesia recovery room, or an intensive care unit to which seriously ill patients can be assigned, while provision for comprehensive service can similarly be reduced for the patient who can do much toward looking out for himself. The less genuinely sick the patient is, the less special care does he require, and by switching from one category to another, he can permit the hospital to lighten its burden of construction and equipment where little more than hotel-type accommodations are necessary.

The program of the Manchester (Mass.) Memorial Hospital, conducted along these lines, has been of a pioneering nature and has warranted the study and commendation of the Public Health Service and the A. M. A. Already it would appear to offer not only reduction in cost to the hospital and the patient, but the elimination of much expensive service which the undifferentiated hospital must offer to certain patients who might be willing to manage much of their own care and save

money for themselves. Hospitals in difficulties—and which are not—might do well to follow developments when retrenchment or new construction is considered.

(J. A. M. A. 166: 2180 April 26, 1958)

A COMMITTEE FOR THINKING

Our association works well by means of a rather large number of able committees which make a good job of considering fairly specific matters. One might hesitate to suggest the establishment of another one, and perhaps for our scattered membership it might not work unless its members might enjoy periodically a semi-novena in some peaceful spot.

This thought comes from reading about what appears to be a rather unique body set up by the Medical Society of the District of Columbia, no less than a committee on Medical Philosophy, called facetiously by its proposer the "Crystal Ball" Committee. The idea was conceived by Dr. Joseph S. Lawrence, who proposed that the Society establish a committee composed of physicians of a more philosophic turn of mind, who would, on occasion, set aside their daily tasks for a more detached look at current medical problems and their implications for the future.

Though there are many practical difficulties in time and scope in the functioning of such a committee, the idea is intriguing, and all of us will await with concern whatever criticisms or solutions may come from the thinkers on the battleground for many of medicine's problems.

THE POLIO PUSH

It seems fair to guess that the polio prevention program has not proceeded far enough for us to rest on our accomplishments. Figures from many sources indicate deficiencies of coverage of the susceptible population. Campaigns seem to have bogged down in some areas, and the individual physician can go only so far in insistence on immunization.

There appears to be no shortage of vaccine, but a shortage of concern on the part of many

people. How is the desire for immunization to be stimulated, other than by the undesirable event of a sharp out-break of the disease? It might seem that health departments and organizations such as the NFIP should keep up a continuous rather than a sporadic pressure on the public, while doctors stand ready to lend any assistance that might be required.

COMPULSORY HOSPITAL INSURANCE NEXT DOOR

As the discussion of the Forand bill proceeds with its implication of the expanded socialization of medicine, it is disheartening to learn that our neighbors in Canada in the province of Manitoba have established a compulsory hospital insurance plan which will provide complete care in standard ward accommodations and will abolish the connection between Blue Cross and Manitoba hospitals.

The Manitoba Hospital Service Association, a member of Blue Cross by reciprocity, will cease to function as such, and beaurocratic regulation will supplant its arrangements.

With our progressing improvement in our understanding of the basic principles of Blue Cross, and our acceptance of the fairness of its management, we might well be concerned by the trend toward medical socialism in our neighbor.

MINUTES OF COUNCIL MEETING MYRTLE BEACH, S. C. MAY 13, 1958

The first meeting of Council in conjunction with the Annual Meeting of the South Carolina Medical Association was held at the Ocean Forest Hotel on May 13, 1958. The meeting was called to order by the Chairman, Dr. J. P. Cain at 9:15 a. m. All officers and members of Council were present.

The minutes of the Council meeting of October 16, 1957, as published, were read and approved.

The Chairman of Council then presented his report, which is to be read at the House of Delegates, and was followed by the report of the Secretary and of the Executive Secretary. There followed a discussion of the reason for the delay in forwarding membership dues to the American Medical Association, and for the delay in the receipt of cards certifying membership in both the South Carolina Medical Association and the American Medical Association by the membership. It was suggested that possibly certification of State Association membership could be sent on the AMA membership card, and it was moved and car-

ried that the Delegates to the American Medical Association be instructed to bring this suggestion to the House of Delegates of the AMA.

Dr. J. Howard Stokes then presented his report as Treasurer, and it was moved that the audit report be published in the Journal. Dr. Stokes likewise reported as Chairman of the Committee on the American Medical Educational Foundation, and noted that approximately 50% of the membership of the State Association had contributed to this fund.

The Editor of the Journal, Dr. J. I. Waring, then gave his report after which a motion was carried to the effect that the Editor be instructed to abstract and edit the minutes of the proceedings of the House of Delegates and to continue their publication in the Journal. The Editor then presented a suggestion as to a change in the official seal of the Association which was to be presented at a later date to the House of Delegates.

Council then received the reports of the Delegates to the American Medical Association, and on motion the Chairman of Council was instructed to appoint a committee of three to investigate the feasibility of Social Security for doctors.

The President of the South Carolina Medical Care Plan, Dr. G. D. Johnson then presented his report and this was followed by the report of the President of the Association.

Dr. J. I. Waring reported that the Public Relations Counsel, Mr. Francis Taylor, was now employed on a piece work basis, and that he and Mr. Taylor had decided that there was no urgent reason why he should attend all of the sessions of the State Association Annual Meeting; the decision as to whether or not this policy would be continued was referred to the Publicity Committee, consisting of Dr. J. I. Waring, Chairman, Mr. M. L. Meadors, and Dr. Robert Wilson, Secretary.

Dr. G. D. Johnson reported that the Duke Endowment had undertaken a policy of furnishing nursing consultants to various hospitals on request, for the purpose of acting in an advisory capacity regarding nursing training, hospital management and such topics, with the further provision that this endeavor be approved by the State Hospital Association, the State Nurses Association and the State Medical Association. Dr. D. L. Smith noted that he had been unable to obtain specific details from the Duke Foundation, and it was not altogether clear as to exactly what was requested of the State Medical Association. After some discussion a motion by Dr. Weston was carried to the effect that Council request the House of Delegates to authorize an investigation of this matter, and if desirable and urgent to give its approval.

The Secretary reported that the certificates for past Presidents, past Vice-Presidents, and past Chairmen of Council had been prepared and were ready for distribution. A letter from Dr. Thomas Parker, requesting that the South Carolina Medical Association

again sponsor an essay contest for 1959, was read and Council gave its approval to this request. A letter from Dr. O. B. Mayer, Chairman of the Committee to investigate a permanent building headquarters for the Society was read and on motion the committee was continued. Dr. Mayer also reported in another letter the work of the Committee on Highway Safety, which was to be presented to the House of Delegates.

The Secretary presented a letter from the American Medical Association requesting action on a UNIFORM HAZARDOUS SUBSTANCES ACT; it was instructed that this matter be brought to the attention of the House of Delegates without recommendation.

Dr. William Weston then reported a resolution from the Columbia Medical Society to the effect that the South Carolina Medical Association endorse the re-evaluation of immunization programs of Public Health Departments, pointing out that (1) Local Medical Societies should be consulted and have jurisdiction over the immunization program of Health Departments; and, (2) That Health Departments should give immunization to indigent patients only with patients able to pay to receive their immunization from their local physicians. Council directed that this be presented to the House of Delegates without recommendation.

The Secretary read a letter from Dr. Joe E. Freed, Secretary-Treasurer of the South Carolina District Branch of the American Psychiatric Association, announcing the appointment of a Committee from the Columbia Medical Society to study the problem of liaison with psychologists. This was received as information.

A letter was read from Dr. J. R. Young, Chairman of the Committee on Cancer, suggesting that each year the Scientific Program include a lecture on cancer by some outstanding student of the subject. This was referred to the Committee on Scientific Program for the next year.

The Secretary read letters from Exhibits-On-Film, and from the Smith, Kline and French Company, which were received as information. He announced that invitations had been received from non-professional groups in Charleston, Columbia, and Greenville, inviting the Association to hold its 1959 meeting in those localities.

Dr. Charles N. Wyatt, Chairman of the Committee on Civilian Defense, reported at length of the activities of this committee and was accorded the thanks of Council for his work in this direction.

Dr. G. D. Johnson announced that nominees for the Board of Directors of the South Carolina Medical Care Plan, to be presented at the meeting of the Corporation, were as follows: Drs. A. V. Bozard, G. D. Johnson, C. J. Lemmon, Jr. and Messrs. A. P. Nisbet, Graham Segars, and T. C. vanDiver.

The Council then approved the nominations of the following for consideration of the House of Delegates, to be elected to the Mediation Committee.

Second District—Drs. Weston Cook and Sam Garrison.

Fifth District—Drs. Roderick MacDonald and Ripon LaRoche.

Eighth District—Drs. W. R. Tuten, Jr. and Michael Watson.

Council then approved the nomination of Dr. J. H. Stokes, to be submitted to the House of Delegates for election as Treasurer.

Mr. M. L. Meadors, Executive Secretary, then reported that the Veterans Administration was not going to renew its contract with the State Medical Association but was going to continue to finance domiciliary care for Veterans on an off-contract basis; a review of the fee schedule for these services was suggested, and it was directed that a committee be appointed by the Chairman to review this matter.

The Executive Secretary then reported the study of consideration of giving Blue Cross and Blue Shield benefits to all employees of the South Carolina Medical Association (with the exception of himself) as "fringe benefits". It was moved and carried to include all employees of the Association in this plan, and to give them all contracts for Blue Cross and Blue Shield coverage.

The Executive Secretary then presented a letter from Dr. N. K. Walsh, requesting the appointment of a committee to meet with representatives of the South Carolina Psychological Association to try and cooperate with them in initiating legislation to certify the psychologists in the state. This was referred to the House of Delegates without recommendation.

A letter was read from Dr. G. S. T. Peeples, State Health Officer, regarding sterilization of the mentally incompetent and regarding the radiation hygiene act. These were approved in principle and likewise referred to the House of Delegates for their action.

Dr. D. L. Smith, President, announced that a Committee had been formed to report on the advisability and need for a liaison committee between the South Carolina Medical Association and the Medical College of South Carolina, and was to present its report to the House of Delegates.

There was no further business and the meeting adjourned at 7 p. m.

Respectfully submitted,
Robert Wilson, M. D.
Secretary

MINUTES OF COUNCIL MEETING MYRTLE BEACH, S. C. MAY 14, 1958

A second meeting of Council was held at 9 a. m. on the morning of May 14th at the Ocean Forest Hotel, Myrtle Beach, S. C. The meeting was called to order by the Chairman, Dr. J. P. Cain. Members present were Drs. Scurry, Burnside, Weston, Fleming, Brewer, B. Smith, Wyatt, Gressette, Waring, Johnson, Wilkerson, Eaddy, D. L. Smith, Prioleau and Mr.

M. L. Meadors.

The minutes of the meeting of May 13th in rough were presented by the Secretary and were reviewed.

Mrs. B. Workman, President of the Medical Auxiliary, Mrs. George Orvin, President-Elect of the South Carolina Medical Auxiliary, Mrs. Hubbard, Chairman of the National Civilian Defense Council of Tennessee, and Mrs. Wilkins, Treasurer of the South Carolina Medical Auxiliary, presented their reports which were received and commended by Council.

The Chairman of Council then announced that it was his suggestion that the following resolution be introduced at the meeting of the House of Delegates:

WHEREAS, The American Medical Association, American Dental Association, American Hospital Association and American Nursing Home Association, cooperating in the effort to meet the challenge presented by the increasing number of older people in the United States, have established a joint council to improve the health care of the aged; and

WHEREAS, The stated objectives of the Joint Council are: (1) To identify and analyze the health needs of the aged; (2) To appraise available health resources for the aged; and (3) To develop programs to foster the best possible health care for the aged regardless of their economic status."

Now, therefore,

Be it resolved by the House of Delegates of the South Carolina Medical Association, that the National Congress be urged to refrain from the passage of laws which would hamper the efforts of the Joint Council by making the aged of our population more dependent upon the Federal Government, so that these great national health organizations may have reasonable time to work out the solution of the problems in the traditional American way;

That a copy of this Resolution be forwarded to our two Senators and to the Representative of each of the six Congressional Districts of the State, requesting them to use their best efforts to implement the purpose expressed herein.

Council then approved the introduction of this

resolution as new business to the House of Delegates.

There was no further business and Council adjourned at 9:25 a. m.

Respectfully submitted,
Robert Wilson, M. D.
Secretary

**MINUTES OF COUNCIL MEETING
MYRTLE BEACH, S. C.
MAY 15, 1958**

Council reconvened on May 15, 1958 at the Ocean Forest Hotel at 8:30 a. m. Members present included Drs. Burnside, D. L. Smith, Wyatt, B. Smith, Crawford, Eaddy, Cain, Wilson, Fleming, Gressette and Mr. M. L. Meadors.

The meeting was called to order by the Chairman, Dr. J. P. Cain.

As the first order of business Dr. J. P. Cain was re-elected Chairman of Council, Dr. Charles N. Wyatt as Vice-Chairman and Dr. A. C. Bozard as Clerk.

Dr. C. N. Wyatt, Chairman of the Committee on Civilian Defense, suggested that the smaller hospitals be required to have plans for their part in general catastrophies, and that such plans be made a requirement for licensing. After some discussion Council passed a motion to the effect that Dr. Wyatt be given power to act in this regard.

The House of Delegates had already decided on Columbia as the place of the next meeting, and Council designated the second week in May for the time of the next annual meeting, to be held at the Columbia Hotel, and designated a committee of the President, the Executive Secretary, and the Councilor from the Second District to make the necessary arrangements.

There was no further business and Council then adjourned, to reconvene in the fall at the call of the Chairman.

Respectfully submitted,
Robert Wilson, M. D.
Secretary





William Weston, Jr., M. D., President Elect

Dr. Weston was born at Columbia, S. C., on August 25, 1898. He attended elementary school at Columbia, and finished Episcopal High School, Class of 1916. He is a graduate of the University of South Carolina, Class of 1919 (B. A. degree), a graduate of the University of Virginia Medical School 1923, and was intern at Johns Hopkins Hospital 1923-1925, and chief resident physician at Children's Hospital of Philadelphia 1925-1926. He is licensed by University of the State of New York to practice Medicine and Surgery. He was 1927 (Extern) Babies Hospital 1926-1927 and Nursery and Child's Hospital 1927 and on the Faculty Southern Pediatric Seminar 1940.

He became associated with his father, William Weston, M. D., in the practice of pediatrics in Columbia, in April 1928.

Dr. Weston is a member of the Columbia Medical Society, South Carolina Medical Association, American Medical Association, Fellow in the American Academy of Pediatrics, Member of Southeastern Allergy Association, and Southern Medical Association. He was Program Chairman of Columbia Medical Society for 13 years, and is now Co-Chairman. He was President of Columbia Medical Society in 1951. He is now District IV Chairman

of American Academy of Pediatrics and has held this office since 1954. He has been a Delegate to the American Medical Association from S. C. Medical Association since 1951. Chairman of Section on Pediatrics, A. M. A. 1955. He is Pediatric Consultant of South Carolina State Hospital, Pineland Division, and is Pediatric Consultant of South Carolina State Board of Health, Rheumatic Fever Clinic.

Married Henrietta Nelson on October 22, 1932. Has two sons and one daughter. The sons, William Weston, III and Shannon Nelson Weston, are both graduates of the University of South Carolina. William Weston, III is now in Medical School at Duke University and Nelson will enter the Medical College of South Carolina at Charleston this fall. The daughter, Henrietta McWillie Weston, is a student at St. Mary's Junior College, Raleigh, North Carolina.

In addition to taking an active part in the organizations of his profession, Dr. Weston is interested in the religious, civic, and cultural life of his city and state. He is a member of Trinity Episcopal Church where he has served as vestryman. He is a member of Rotary Club. He served as a member of Columbia Housing Authority and later as Chairman for a number of years. He is a member of Forest Lake Country Club. He has served on the Advisory Board of the Crippled Children Society of S. C. for several years.

Dr. Weston is the second member of his family to achieve election to the presidency of the Association, and enjoys the distinction of being the only president who has been elected to office during the lifetime of his parental predecessor in the same office.



Dr. William Weston

Dr. William Weston, father of Dr. Weston, Jr., lives in Columbia, and is well known and loved by the many members of the Association with whom he has worked in the past, and is a man who has enjoyed many distinctions in his career. Among the many offices he has held, he too was Delegate to the American Medical Association for many years, and he was president of our Association in 1914.

The mutual reflection of achievement is outstanding in the father and son.



Dr. Henry C. Robertson, Jr., New Vice President.

Dr. Robertson was born in Charleston, was educated in the city schools, at the University of the South, Sewance, Tenn., graduating in 1931, and graduated from the Medical College of S. C. in 1935. He served an internship at the Orange Memorial Hospital, Orange, N. J. and thereafter was medical resident in Roper Hospital. He was in the general practice of medicine in Charleston from 1937 to 1942, when he entered the army and remained in service for the next 4 years, most of the time being spent in the 8th Infantry Division. From 1946 to the present, Dr. Robertson has been in the practice of internal medicine in Charleston.

He is married, has 3 children and lives at 5 Ladson Street. He is interested in growing

camellias, in music, and in fishing, as hobbies. He holds a position on the faculty of the Medical College, being assistant professor of medicine, and is director of the health program of the School of Nursing of The Medical College. He was formerly senior warden of St. Philip's Episcopal Church, and at present is a member of the Boards of Directors of the Charleston Rotary Club, The American Red Cross, (Charleston Chapter), The Crippled Children Society, and is a member of the Advisory Board of The Salvation Army. He is a member of the Board of Commissioners of Roper Hospital, Charleston.

SOUTH CAROLINA MEDICAL ASSOCIATION COMMITTEES, 1958-59

1. Committee on Scientific Program

Dr. O. B. Mayer, Chairman
1220 Pickens St., Columbia

Dr. William Weston, Jr.
1310 Adger Rd., Columbia

Dr. George Bunch
1512 Marion St., Columbia

Dr. Edmond R. Taylor
1515 Bull St., Columbia

Dr. E. R. Barber
Lancaster

Dr. R. W. Hanckel
96-A Bull St., Charleston

Ex Officio:

Dr. Robert Wilson
Charleston

Dr. R. L. Crawford
Lancaster

2. Committee on Public Health

Dr. Thomas R. Gaines, Chairman
126 E. Earl St., Anderson

Dr. John Buchanan
Winnsboro

Dr. O. B. Mayer
1220 Pickens St., Columbia

Dr. J. C. Harris
Lancaster

Dr. Halsted M. Stone
Chester

3. Memorial Committee

Dr. Martin M. Teaguc, Chairman
501 S. Harper St., Laurens

Dr. Thomas G. Goldsmith
200 E. North St., Greenville

Dr. J. Howard Stokes

- 161 W. Cheves St., Florence
4. Committee on Cancer
Dr. H. R. Pratt-Thomas, Chairman
16 Lucas St., Charleston
Dr. Thomas A. Pitts
Baptist Hospital, Columbia
Dr. Alton G. Brown
Clinic Bldg., Rock Hill
Dr. James R. Young
126 E. Earl St., Anderson
Dr. Percy D. Hay, Jr.
McLeod Infirmary, Florence
Dr. Sam H. Fisher
Greenville General Hosp., Greenville
 5. Committee on Legislation & Public Policy
Dr. Frank C. Owens
1319 Laurel St., Columbia
Dr. Joseph I. Converse
413 N. Main St., Greenville
Dr. George W. Price
120 Hall St., Spartanburg
Dr. Alton G. Brown
Clinic Bldg., Rock Hill
Dr. Henry C. Robertson, Jr.
165 Rutledge Ave., Charleston
Dr. George H. Orvin
149 Wentworth St., Charleston
Ex Officio: Mr. M. L. Meadors
309 W. Evans St., Florence
 6. Committee on Welfare & Rehabilitation
Dr. Angus Hinson
Rock Hill
Dr. John A. Siegling
Charleston
Dr. John K. Webb
12 S. Calhoun St., Greenville
Dr. Roderick Macdonald
Rock Hill
Dr. Ben N. Miller
1433 Gregg St., Columbia
 7. Committee on Liaison with Allied Professions
Dr. William R. LaRoche, Jr., Chairman
307 De Kalb St., Camden
Dr. James L. King
1319 Laurel St., Columbia
Dr. Douglas Jennings, Jr.
132 Marlboro St., Bennettsville
Dr. Harold E. Jervy, Jr.
1806 Hampton St., Columbia
Dr. Charles R. May
 - 210 Market St., Bennettsville
Ex Officio: Mr. M. L. Meadors
309 W. Evans St., Florence
 8. Committee on Care of the Patient
Dr. Joseph H. Cutchins, Chairman
100½ Pendleton St., Easley
Dr. Weston C. Cook
1730 Hampton St., Columbia
Dr. J. C. Harris
W. Gay St., Lancaster
 9. Advisory Council to Woman's Auxiliary
Dr. Francis G. Cain, Chairman
Charleston
Dr. Thomas R. Gaines
126 E. Earl St., Anderson
Dr. J. Dechard Guess
200 E. North St., Greenville
Dr. D. Strother Pope
1417 Hampton St., Columbia
Ex Officio: Mr. M. L. Meadors
309 W. Evans St., Florence
 10. Committee on Medical Education Foundation
Dr. J. Howard Stokes, Chairman
161 W. Cheves St., Florence
Dr. Keitt Smith
1 Medical Court, Greenville
Dr. Kirby D. Shealy
1419 Blanding St., Columbia
Dr. John A. Siegling
70 Ashley Ave., Charleston
 11. Committee on Medical & Hospital Insurance Contracts
Dr. Richard W. Hanckel, Chairman
96-A Bull St., Charleston
Dr. Clay Evatt
Charleston
Dr. F. C. Owens
1319 Laurel St., Columbia
 12. Committee on Rural Health
Dr. Keith F. Sanders, Chairman
Kingstree
Dr. John C. Buchanan, Jr.
206 S. Congress St., Winnsboro
Dr. Harold S. Gilmore
Nichols
Dr. Franklin L. Geiger
Wade Hampton Office Bldg., Columbia
Dr. Charles M. Graham
Clio
 13. Committee on Historical Medicine

- Dr. J. I. Waring, Chairman
82 Rutledge Ave., Charleston
Dr. Chapman Milling
1512 Marion St., Columbia
Dr. R. M. Pollitzer
211 E. Coffee St., Greenville
Dr. Heyward Gibbs
1417 Hampton St., Columbia
14. Committee on Civil Defense
Dr. Charles N. Wyatt, Chairman
301 E. Coffee St., Greenville
Dr. R. Y. Wescoat
308 S. Main St., Lancaster
Dr. Bachman S. Smith, Jr.
77 Rutledge Ave., Charleston
Dr. William C. Herbert, Jr.
109 Catawba St., Spartanburg
15. Committee on Industrial Medicine
Dr. John M. Perry, Jr., Chairman
Sonoco Products Co., Hartsville
Dr. H. Leon Poole
324 St. John St., Spartanburg
Dr. James L. Hughes
113 S. Main St., Greer
16. Committee on Coroners-Medical Examiners
Dr. H. R. Pratt-Thomas, Chairman
16 Lucas St., Charleston
Dr. D. Strother Pope
Columbia
Dr. R. F. Zeigler
305 W. Palmetto St., Florence
Dr. Robert Solomon
Moncks Corner
Dr. Wm. Hunter
Clemson
17. Committee on Certification of Psychologists
Dr. Joe Freed, Chairman
Columbia
Dr. John M. Brewer
Kershaw
Dr. F. C. Owens
1319 Laurel St., Columbia
18. Medical Advisory Committee to the Crippled Children Society of South Carolina, Inc.
Sam G. Lowe, Jr., Rock Hill
John Bell, Greenwood
T. G. Goldsmith, Greenville
T. R. Gaines, Anderson
- Philip McNair, Aiken
Joseph I. Waring, Charleston
John Arthur Siegling, Charleston
William Weston, Jr., Columbia
Charles Hanna, Spartanburg
James T. Green, Columbia
George Dean Johnson, Spartanburg
Fred E. Kredel, Charleston
Harry W. Mims, Charleston
Julian P. Price, Florence
C. Guy Castles, Columbia
Co-Chairmen:
Joseph I. Waring, Charleston
William Weston, Jr., Columbia
Ex-Officio:
R. L. Crawford, Lancaster
President, S. C. Medical Association
19. Committee on Maternal Health
Dr. L. L. Hester, Chairman
Charleston
Dr. Horace M. Whitworth
Greenville
Dr. Hilla Sheriff
Columbia
Dr. Richard Johnston
St. George
Dr. W. M. Bryan
Columbia
Dr. Herbert Black
Columbia
Dr. J. P. Horton, Jr.
Lancaster
Dr. Joe Smith
Lancaster
20. Committee on Infant and Child Health
Dr. Walter M. Hart, Chairman
Florence
Dr. Ethel Madden
Columbia
Dr. J. I. Waring
Charleston
Dr. Swift Black
Dillon
Dr. Fred Adams
Spartanburg
Dr. Joseph D. Thomas
Denmark
Dr. Herbert Black
Columbia
Dr. W. A. Hart
Columbia



BLUE CROSS . . . BLUE SHIELD



PREPARATION OF SERVICE REPORTS

Reasonable care, legibility, and thoughtfulness in preparing service reports pay off—frequently in dollars and always in expediting handling and avoidance of unnecessary correspondence. Only those facts stated in the report are known to the clerk who handles the claim. If the facts are clearly stated, correctly coded, and if the physician's usual charge for the type of service performed is inserted, it is frequently a simple matter to determine the fee allowance. Carelessness in any one of these particulars frequently results in the report having to be sent to the medical director to decipher the extent of the service, to reconcile the service with the stated diagnosis, to reconcile the service with the stated charge, to reconcile the service with the reported code number, or to determine the appropriate code number. Not infrequently, even his medical background and experience do not make it possible for him to make the reconciliation or to fill in the gaps in the information.

It has been frequently asked, why do you wish to know the physician's usual fee. That is his personal business, and certainly it is no one else's. Right you are to a degree. However, there is usually no guilt sense involved in stating it. One of my personal friends, when I suggested that the fee stated on his Blue Shield report seemed much greater than his usual actual fees, laughed and said that he wanted to look like a "big shot" to us in the Blue Shield office, and so he blew up his stated fees.

The statement of your usual charges for the service rendered serves both a general and a personal purpose. It enables the Plan to keep track of the usual charges for many frequent operations performed. That in turn helps the Plan's study of the adequacies and inadequacies of the fee schedule, and it helps to gauge the general satisfaction or dissatisfaction of the doctors with the fees provided.

As to its more personal benefits: if there is great disagreement between the allowed fee and the stated charges, there is an inherent suggestion that the services rendered have not been fully reported or that unusual difficulties have been met with and have not been reported. In either instance, the doctor is likely to be sent a letter calling to his attention the disparity between the fee allowance and his charges and asking for a more complete report. Such a report receives individual consideration and often results in a larger fee award than would have been the case otherwise. On the other hand, the Plan undertakes to pay only up to the amount provided in the fee schedule. If the case is so minor, that the doctor does not charge as much as the schedule allows, the Plan pays him only

the amount of his charge. This is right and proper, and I am sure that no right-thinking doctor would care to take advantage of the Plan by allowing it to pay him more than he would have charged his patient.

A year's experience with our relative value schedule has shown that most operations done can be coded from the book. Occasionally, a new procedure or a procedure similar to one coded but not identical with it is reported. Rarely a new code number is inserted in the master book in the Plan's office, more as a memorandum of what relative value has been set than as a guide to the coding of a future report.

There are a few procedures, coded and assigned a relative value, which are not covered in the standard Blue Shield contract. The fact that they are in the book of relative values is no indication that they are covered procedures. The only guide to coverage is the subscription agreement, or contract. When in doubt as to whether or not a procedure is covered by the contract, the contract should be consulted rather than the so-called fee schedule.

Many doctors are missing a marvelous opportunity for service to their Blue Shield patients in that they are advising elective operations a few weeks or months before the expiration of a required waiting period. To do an elective operation for a condition which, because of its pathological nature, must have been present on the effective day of the contract, is not only embarrassing to the doctor, but it is costly to the patient and puts everyone concerned in a bad humor. The contract is quite clear regarding waiting periods. It is not necessary for the patient or one of his family or for the physician to know that the condition was present on the effective date of the contract. If a physician—and that includes the medical director of the Plan—can be reasonably certain that the condition must have been present on the effective date, the waiting period applies. No one has to know exactly when the condition began. Gall stones do not develop in a day. Fibroid tumors large enough to require or indicate hysterectomy do not become so in a matter of weeks. Maternal birth injuries go back at least to the last labor. Intestinal obstruction caused by adhesions is a complication of the adhesions and the date of the beginning of the adhesions can usually be determined by a study of the past history. Cancer with distant metastases is not an acutely arising condition, and its presence must be counted in months instead of days in most cases.

Doctors can be of great assistance to the Plan in explaining these things to their patients before they operate. After the operation is done, it is only human

nature to try to conserve the patient's insurable interest and to avoid embarrassing explanations. If explanation is made before the operation, the only embarrassment which may be encountered is an occasional request that the doctor make himself a party to fraud by incorrectly reporting the case.

J. Decherd Guess
Medical Director

NEWS

DR. J. C. HEDDEN ELECTED HEAD OF TRUDEAU SOCIETY

Dr. J. C. Hedden of Spartanburg was elected president of the South Carolina Trudeau Society, medical section of the South Carolina Tuberculosis Association, as the group met at the Hotel Columbia as part of the larger organization's annual meeting in April.

Dr. Robert Black of Bamberg was elected vice president; and Dr. Henry Bayon of Columbia, secretary-treasurer.

Two Greenville doctors spoke at a meeting of the Greenville County Medical Society in May.

Dr. Harold Jackson, a pediatrician, spoke on "Duodenal Ulcer in Children" and Dr. Raymond Ramage, who practices thoracic and general surgery spoke on "Pneumonectomy in Advanced Bronchogenic Carcinoma."

Drs. Anderson, Anderson and Gowan, have moved from Pendleton Street Medical Court to Vardry Medical Court, Greenville where they are now occupying their new building, which is number 6. Once the home of a Greenville family, the new medical court has attracted much attention.

Frederick E. Nigels, M. D. announces that his practice hereafter will be limited to cardiology and vascular disease. 51-C Montague Street, Charleston.

MEDICAL COLLEGE GRADUATION IN JUNE

Top graduate in the medical school was Nicholas G. Forlidas, Jr., and second was Walter J. Roberts, Jr.

MEDICAL DEGREES

Those receiving M. D. degrees were:

Wallace Rodney Mullins, John Sughrue, Jr. and Andrew Gibson Denham, all of Charleston; Marshall Livingston Shearer, Jr. of North Charleston, Robert Gardiner Bradbury, Willie Lee Davis and James Carlisle Hewitt all of Orangeburg; Melvin DuBose Medlock, Robert Nicholson Milling, Walter James Roberts, Jr., Thurnond Otto Walker, Edwin Robertson Worrell, Frank James Wyman, Jr., Eugene Middleton Baker, Jr. and George Lynn Derrick, all of Columbia.

William Carey Miller, Jr., Ollie Macon Smithwick, Jr., James Luther Stewart, Jr., Eugene Cary Cox and

William Harold Hill, all of Greenville; Theodore Branch Rheney and Charles Mansfield Webb, both of Spartanburg; Kenneth Jackson Parham and Lawrence Hampton Craig, both of Anderson; Charles Maynard Waters, Jr. and John Furman Finklea, both of Florence.

Samuel Perry Davis and Patrick Harley Dennis, both of Sumter; Robert Lee Sawyer and Fletcher Carl Derrick, Jr., both of Johnston; William David Clarkson and Franklin Drucker, both of Kingstree; James Monroe Hilton of Kershaw, Edith Hutto of Ridgeway, Marvin Kirsh of Clober, Fred Marion Lambert of Lancaster, Rhett Barnwell Myers of Moncks Corner.

Charles Edwin Powe of Hartsville, Samuel Jerome Segal of Rock Hill, Robert Lancaster Worrell of Batesburg, James Raynor Barham, Jr. of Marion, George Wesley Campbell of Edgefield, Waddy William Chapman, Jr. of Inman, Robert Edward Davis, Jr. of Camden, Francis Marion Dwight of Wedgefield, Carolyn Edwards of Latta, Dexter Mobley Evans, Jr. of Lake City, Rudolph Farmer, Jr. of State Park, John Spearman Floyd, III of Silverstreet, Nicholas George Forlidas, Jr. of Clemson, Billy Wilton Fortner of Pickens, Ralph Samuel Gruenberg of Timmonsville and Grady Hinson Hendrix of Health Springs.

DEC. 5 GRADUATES

Albert Peter Cernugel and Ralph Dudley Comer, both of Charleston; Archibald McLeish Martin and George McGregor Whitaker, both of Columbia; Saied Ameen of Great Falls, Callis Jensen Anderson of Hartsville, J. M. Bennett, Jr. of Ruffin, Danny Reese Blackwell of Kershaw, Maynard William Bland of Gaffney, Allan Preston Bruner, III of Fort Motte.

Lawrence Sidney Connor of Bowman, Clyde Francis Deal of Greenwood, Jack Thomas Fakoury of Myrtle Beach, William Justin Floyd of Anderson, Ira Boyce Horton, Jr., of Bethune, Lewis Earle Jones, Jr. of Ware Shoals, Robert Ernest McDowell of Newberry, Norman Selby Richardson, Jr. of Darlington, William Mallory Shirley of Belton, David Kershaw Stokes, Jr. of Camden, Carl Henry Strom of McCormick.

Dr. Harwood Beebe, Jr. has moved his office to 203 Pine Street, Spartanburg.

Dr. Bernard E. Ferrara has moved his office to The Medical Arts Building, 65 Gadsden St., Charleston.

Dr. Robert Wilson, Charleston, has been elected president of the Poetry Society of South Carolina.

MR. LORANZ TO RECEIVE HONORARY DEGREE

The Southern Medical Association is pleased to announce to his many friends that Mr. C. P. Loran received an Honorary Degree of Doctor of Science (D. Sc.) from Erskine College in Due West, South Carolina.

The degree was conferred during the 116th com-

mencement held in Memorial Hall on the campus on June 2, 1958.

Erskine College, founded in 1839, is a co-educational college and seminary of the Associate Reformed Presbyterian Church. In conferring this degree, the College is recognizing Mr. Loran's contributions to medical progress through his services to the Southern Medical Association. This recognition has added significance since he is an active Presbyterian, having been a church officer for more than fifty years and is now the Senior Elder in his church in Birmingham.

Mr. Loran began his career with the Association in 1912 in the capacity of Business Manager. In 1921 he was elected Secretary, Treasurer and General Manager with the title of Secretary-Manager. Since 1954, he has served in an active advisory and professional relations capacity and is now in his forty-sixth year of service.

Thus, as Erskine College honors this senior layman of medical society administrators, it is honoring by indirection the Southern Medical Association and the physicians of the South in whose behalf this distinguished career has been pursued.

DEATHS

DR. ROBERT L. RALSTON

Dr. Robert Linton Ralston, 38, of 105 Eastwood Circle, Spartanburg, died unexpectedly April 26.

A native of Middlesboro, Ky., Dr. Ralston had been in Spartanburg for the last six years.

Dr. Ralston was a graduate of the Mt. St. Mary's College of Emmitsburg, Ind., and Georgetown University Medical School of Washington, D. C. He did post graduate work at Tulane University at New Orleans, La.

DR. OLIN SAWYER

Dr. Olin Sawyer, 85, retired physician and surgeon of Georgetown, died June 6 at Georgetown County Memorial Hospital after an illness of some months.

Dr. Sawyer was born January 1, 1873, in Edgefield County near Johnston.

He was graduated from Johnston High School, and underwent his pre-medical training at the University of South Carolina. He graduated from the Medical College of South Carolina in 1901, and began his practice in Georgetown immediately afterwards.

For 36 years he was chief surgeon for the old Atlantic Coast Lumber Corp. at Georgetown, until the company closed in the early 1930s.

Dr. Sawyer entered the field of politics in 1908, when he served a term as a member of the House of Representatives. He also served as a member in 1923-26, 1929-30, and 1934-40. He was elected to the Senate in 1941, and served until he retired in 1948, due to the ill health of his wife.

He also served as an alderman of the City of

Georgetown, and was mayor of the city from 1916 to 1920.

During World War I Dr. Sawyer served as county chairman of the American Red Cross.

He also served as a presidential elector in 1904, and had been chairman of the County Democratic Executive committee, chairman of the city Board of Health, and a delegate to the National Democratic Convention in Philadelphia in 1936. He also had served as a surgeon in the S. C. V. Cavalry, with the rank of major.

DR. P. H. KENNEDY

Dr. Patrick Henry Kennedy died May 31. He was 73.

Dr. Kennedy was a native of Charleston. He attended the Medical College of South Carolina and graduated from the Creighton University School of Medicine in Omaha, Neb. He practiced for six years in Macon, Ga., after post graduate work in the School of Surgeons and Physicians in New York City.

After several years of practice in Florida, Dr. Kennedy attended Mercer University at Macon and earned a degree in law. He practiced law in Georgia and in Charleston.

Dr. Kennedy entered politics in this state in the 1920s, and was elected to the House of Representatives, where he served one term. He was also a candidate for Congress from the First District, opposing the late U. S. Rep. Tom McMillan.

ANNOUNCEMENTS

MEETING AT WRIGHTSVILLE BEACH

The New Hanover County Medical Society will hold its twelfth annual Medical Symposium at Wrightsville Beach on Friday, August 1st.

Speakers and their subjects will be:

The Significance of Hematuria by Kenneth Lynch, Jr., M. D., Professor of Urology, Medical College of South Carolina.

Office Gynecology by Edmund R. Novak, M. D., Assistant Professor Gynecology, Johns Hopkins Hospital.

The Emergency Treatment of Fractures by Milton J. Hoover, M. D., Professor of Orthopedic Surgery, Medical College of Virginia.

The Management of Infant Diarrhea by Robert E. Cooke, M. D., Pediatrician in Chief, Johns Hopkins Hospital.

Uses and Abuses of Antibiotics by Ivan L. Bennett, Jr., M. D., Professor of Medicine, Johns Hopkins University and Head of the Biological Division, Johns Hopkins Hospital.

This symposium is approved by the American Academy of General Practice for postgraduate training credit. There is no registration fee.

There will be a Ladies' Dutch Luncheon at 1:00

P. M., and a social hour and dinner for doctors and their wives at Lumina Ballroom in the evening.

A number of hotels and cottages at Wrightsville Beach will accept reservations for this meeting, but reservations should be made as early as possible.

POSTGRADUATE OBSTETRIC-PEDIATRIC SEMINAR

**September 8, 9, 10, 1958
Daytona Beach, Florida**

TENTATIVE PROGRAM

Monday, September 8

Pediatric Day

9:00 A. M.

Surgical Management of Anomalies of Newborn

Pediatric Surgeon

Speaker to be Announced

Current Use of Antibiotics in Relation to Resistant
Organisms

Dr. Edith Potter

or

Dr. Ralph Platou

Tulane University

Nutrition of the Newborn

Dr. James Hughes

University of Tennessee

Newborn Feeding Schedule

Dr. Walter Sackett

Miami, Florida

Round Table Discussion

(Including all Speakers)

Tuesday, September 9

9:00 A. M.

Management of Heart Disease in Pregnancy

Dr. W. Proctor Harvey (Tentative)

Georgetown University

Papanicolaou Smears and Cancer in Pregnancy

Dr. Herbert Schmidt

Northwestern University

Tuberculosis and Chronic Disease Related to Preg-
nancy and Therapeutic Abortion

Dr. Gordon Douglas

Cornell University

Afternoon

Recreation: Golf, Fishing, Swimming

8:00 P. M.

Round Table Discussion

(Including all Speakers)

Wednesday, September 10

9:00 A. M.

Management of the Minor Complaints of Pregnancy

Dr. Mary Elizabeth Johnston

A. A. G. P.

Tazewell, Virginia

Nutrition and Weight Gain in Pregnancy

Dr. John B. Youmans

Vanderbilt University

Emotional Problems of Mother and Infant

Speaker to be Announced

The Commission on Education, American Academy
General Practice has approved the OB-Ped Seminar
for 15 hours of Category I for credit.

Sponsors: The Maternal and Child Health Divi-
sions of the Florida, Georgia, Alabama, and South
Carolina Departments of Health and also the Maternal
Welfare Committees of these States.

Dr. Leon Banov, Jr. of Charleston presented a
scientific exhibit, "Nitrofurazone in Anorectal Wound
Healing", in San Francisco at the June meeting of
the American Medical Association. The exhibit is
based on a study of the healing of postoperative ano-
rectal wounds and is documented by serial color
photographs. This investigational project was carried
out under the auspices of the Department of Surgery,
Medical College of South Carolina.

WHAT ARE WE DOING IN NUTRITION EDUCATION IN SOUTH CAROLINA?

1. Some South Carolina colleges offer Nutrition
Courses for Home Economics students, but no
courses are specifically provided for students other
than Home Economics majors.
2. One state supported college offers courses in Plant
and Animal Nutrition, but no courses in Human
Nutrition.
3. No courses in Nutrition are offered in South Caro-
lina colleges for teachers or potential elementary
teachers.
4. No courses in Nutrition are offered in South
Carolina colleges for parents or potential parents
(other than Home Economics majors).
5. No college in South Carolina, private or tax sup-
ported, offers post graduate courses in Nutrition.
(Source of information—College Catalogues.)
6. No Hospital in South Carolina provides a Dietetic
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An Analeptic Tranquilizer for senile psychoses, report of clinical and pharmacological studies of Nicozol with reserpine, by Proctor, R. C., Bailey, W. H., and Morehouse, W. G., Columbia. J. Am. Geriatrics Soc. 6:291, April, 1958.

Clinical and pharmacological studies demonstrated that Nicozol with reserpine (pentylentetrazol 100 mg., niacin 50 mg. and reserpine 0.25 mg.) provides a safe and highly effective treatment for senile psychoses. This medication combines the analeptic and vasodilator actions of Nicozol with the tranquilizing effect of reserpine. With this therapy many patients who otherwise would have required institutional care were managed at home with a minimum of nursing attention.

In a series of 75 cases of senile psychoses treated with Nicozol with reserpine, 65 (87%) showed improvement. The therapy afforded relief of agitation and restlessness together with improved memory, behavior, sociability, appearance and tidiness. Symptoms of confusion, aggressiveness, hostility and disorientation were relieved.

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Albamycin in the Treatment of Surgical Infections. D. B. Nunn, M. D. and E. F. Parker, M. D., Charleston. *Amer. Surg.* 24:361 (May 1958)

Thirty-six cases of infection encountered in the General Surgical Service of the Medical Center Hospitals were treated with oral, intramuscular, or intravenous novobiocin (Albamycin.) The antibiotic was also used prophylactically in four patients during the postoperative period. Clinical improvement thought to be definitely related to the use of Albamycin was noted in 26 of the patients with surgical infections. No evidence of infection occurred in the four patients in whom Albamycin was used prophylactically.

Side effects were observed in six patients during the course of treatment. These included an urticarial or morbilliform skin rash, pruritus, mild diarrhea, and an eosinophilia greater than ten per cent. All side effects were easy to control and disappeared within two to three days after discontinuing antibiotic therapy.

In vitro sensitivity tests performed on organisms isolated from patients in this study showed Albamycin to be effective in vitro primarily against gram-positive cocci. This was substantiated clinically by im-

provement in those patients with gram-positive coecal infections.

Subacute Thyroiditis. Furman T. Wallace, M. D., Richard S. Wilson, M. D. and William S. Scott, M. D., Spartanburg. *Tri-State Med. J.* 5:6-7, Feb., 1958.

Subacute thyroiditis or de Quervain's thyroiditis is the rarest type of inflammation of the thyroid gland. It occurred in one case in a series of 248 thyroidectomies of the authors.

The microscopic appearance is one of giant cell granuloma with pseudo-tubercles. Etiology is probably a virus. It is characterized by fever and tender enlargement of the thyroid gland. There may be sore throat and pain on swallowing. The most characteristic thing is its long course with fever frequently lasting for several months.

Cortisone and ACTH sometimes help. X-ray therapy sometimes is effective. Surgery may be necessary to rule out malignancy or to decompress the trachea if obstructive symptoms develop. All three of these means of treatment were used in the reported case. The course was still long with fever persisting for several months. Recovery was complete.

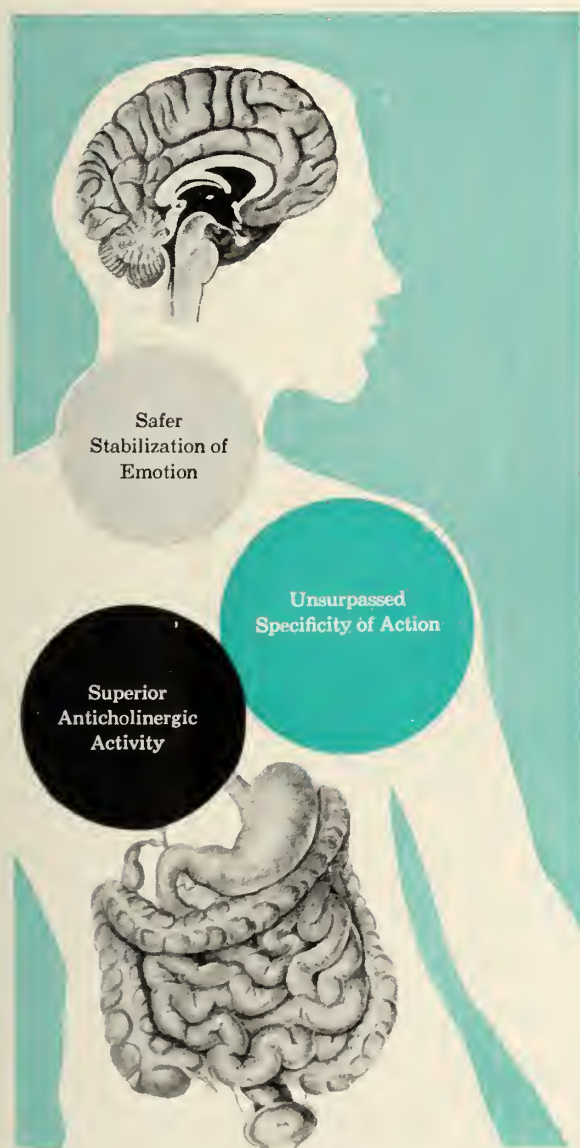
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BOOK REVIEWS

A TEXTBOOK OF CLINICAL NEUROLOGY.
Israel S. Wechsler, M. D. 1958. Philadelphia: W. B. Saunders, Publisher. 735 Pages. Price \$11.00.

In revising his textbook, Dr. Wechsler mentions the more important advances but has not permitted theory to clutter, and unproved methods to overshadow the fundamental truth that successful diagnosis and management of neurological problems are matters of proper evaluation of clinical findings. Herein lies the virtue of his book which is generously illustrated and well-indexed.

In the preface, the author attempts to justify the inclusion of a chapter on "The Neuroses" on the basis that "... the practicing neurologist should be moderately well informed even though he may neither accept nor agree with the analytic point of view." Had he made his justification in the belief that psychiatric disorders are probably the result of metabolic or neuro-chemical derangement, it would be reasonable. The 44 pages which he devotes to this chapter are filled with psychoanalytical terms and definitions, however, and their appearance in such a text is inappropriate.

Rates of interest are smallest on the safest invest-

ment. The chapter on 'Neuroses' should be considered only as a misplaced valueless coupon in an otherwise well-planned, practical and valuable textbook of neurology.

C. Capers Smith, M. D.

GYNECOLOGIC AND OBSTETRIC PATHOLOGY. Emil Novak and Edmund Novak—4th Edition. W. B. Saunders, Phila. 1958. Price \$14.00.

The latest edition of this long heralded classic of pathology is in the nature of a farewell address by a great scientist and scholar. Emil Novak (R. I. P.), the original author of what is a standard textbook for all pupils of obstetrics and gynecology, collaborates with his son, Edmund, to compile this most recent volume. Especially of value to the clinician are the new chapters on the changes in cervical mucus in relation to the various times of menstrual cycle, as well as to those changes encountered in pregnancy. The chapter on chorioepithelioma malignum is certainly voluminous and at the same time is undoubtedly the easiest to understand and the most informative treatise on the subject in the world today. The specialty studies and presentation of abnormalities and diseases of the placenta, together with the new edition of exfoliative cytopathology, are of great value to the practitioner. No library is complete without Novak's Gynecologic and Obstetric Pathology. The illustrations are well



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done, they arouse satisfaction, and give rise to the same ease of understanding that they did in the first edition.

Patricia A. Carter, M. D.

PEDIATRIC INDEX. Edwin F. Patton, M. D. C. V. Mosby Co., St. Louis, 1958. Price \$13.50.

This is a rather gigantic collection of material reduced to relatively brief form and correlated well by a system of cross indexing. It is almost encyclopedic in scope, and includes consideration of symptoms, diagnosis, and treatment in brief. The last section covers techniques and special data.

This is not a textbook, nor is it the quick refresher of knowledge such as the well known *Compend Pediatr* of Davison. It offers an immense collection of facts which can be readily related by virtue of their arrangement. It appears to be a very useful source of information and a help toward diagnosis and treatment for pediatrician and general practitioner alike. The inevitable sample fishing for facts done by the reviewer yielded a very satisfactory catch.

In such sampling the reviewer encountered a few matters about which he might quibble.

The author says he eschews eponyms, but he indulges in descriptions of "Andy Gump chins" and "Dick Tracy jaws" which might be confusing to his international readers. Similarly there seems to be overindulgence in the use of trade names where generic terms would also be more widely understood (or should!). Some we can overlook, but when "Anacin" achieves medical respectability it seems to have gone farther than it deserves. Perhaps another reference list to put us out of our misery and confusion in the terrific spate of drug preparations would be a useful addition in the next edition, which this book is likely to achieve.

J. I. W.

MEMOIRS OF A G. P. by Otis Marshall, M. D. Vantage Press, New York. Price \$3.50.

This is a rather rambling account of the life of a physician, starting in childhood and continuing up to the present later years. It mixes medical experience with the other activities of a busy life, and furnishes many reports of interesting cases seen, although they are in very brief form. This book which seemed to be more the sort of thing that one might write as a memoir for his family and friends rather than for the general reading public.

J. I. W.

VERTIGO AND DIZZINESS, by Dr. Bernard J. Alpers, Grune and Stratton, New York and London, 1958.

This very thorough but concise medical monograph, No. 15 of the Modern Medical Monograph Series published by Grune and Stratton, and edited by Dr. Ervin S. Wright, provides a volume which will be of interest to a large number of physicians in all medical

branches. The book has been written in a way which will direct a physician's attention toward certain basic avenues of approach when confronted with the problem of vertigo and dizziness. Discussion of the symptom and ways in which to properly recognize it is well presented as well as very clearly written sections on the anatomical and physiological mechanisms responsible for it. In the author's own words, he has attempted in this volume to present an approach to the vertigo problem by enabling the reader to systematically develop his investigation of the patient by, in the initial stages of his examination, "determining that true vertigo is present, followed by the visualization, as clearly as is possible, of the mechanisms underlying it."

Vertigo and dizziness is a symptom complex which cuts across all fields of medicine. It is found frequently not only in the patient seen by the neurologist, internist, otologist, and general practitioner, but it is a problem which the general surgeon, obstetrician, and pediatrician frequently see. From the patient's standpoint it is a frightening experience, and the mechanisms responsible for it may arise from such widely separated areas as to be a source of bewilderment unless the examining physician can develop a logical systematic approach to the problem. The design of this monograph is to present in a most thorough but concise manner such a methodical guide for the physician.

For those having more than usual interest in the problem and who may desire to pursue further study of it, an extensive bibliography is included in the monograph. Those articles with good reviews have been especially marked in the group of references appended.

The subject matter of the monograph is handled in eight chapters, the total length of which runs to only 94 pages. Each chapter is quite complete in itself as regards its discussion of the specific subject matter concerned. There is an excellent cross index by means of which specific information can be quickly sought in use of the book as a source of reference. The anatomical and physiological, as well as neurological considerations related to the problem of dizziness in regards to peripheral as well as central origin of the symptom, and the local as well as systemic disease states which may have this as a prominent symptom, are clearly discussed. An adequate section on treatment with medical and in brief outline what may be accomplished by various surgical procedures is presented as the last chapter of the monograph.

Dr. Alpers, who is Professor and Head of the Department of Neurology at Jefferson Medical College, Philadelphia, has in this small volume produced an excellent book which should be of interest to many physicians for purpose of review of this common symptom, and as a source for ready reference in considering this problem which a large number of physicians must do at frequent intervals.

Vince Moseley, M. D.

DRUGS—THEIR NATURE, ACTION AND USE. Harry Beckman, M. D. W. B. Saunders Company, Philadelphia 1958. Price \$15.00.

The general plan, the manner of approach and style of writing makes this an outstanding text particularly useful to the physician in his practice, as well as an excellent textbook for the medical student. It would appear that this book should serve as a foundation for the rational and scientific use of drugs without losing sight of the ultimate objective which is the application of drug therapy in disease. A list of references is appended to each chapter, the purpose of which is to cite monographs in which extended bibliographies may be found for those who wish to go to the original source.

Wm. A. Prout

OFFICE GASTROENTEROLOGY. A. F. R. Andresen. W. B. Saunders Company. Philadelphia, 1958. 707 pp. Price \$14.00.

The author presents a monograph on the entire field of gastroenterology, based on his personal experience in 40 years of practice. It is a well arranged, readable book, directed at the generalist and the internist, but does not qualify as a reference work.

Over the years the author's concept of food allergy as the cause of many gastrointestinal diseases has been a controversial point, and this concept is seen in such statements as "gastrointestinal manifestations of food allergy are undoubtedly as common as those in the skin or the mucous membranes of the respiratory tract" and "allergy is almost invariably the cause of ulcerative colitis". Allergy is also said to be a major cause of peptic ulcer disease and of regional enteritis. The cathartic effect of coffee is ascribed to an allergy rather than to the known effect of caffeine. The author still places much importance on foci of infection as causes of ulcer and ulcerative colitis, stating that "removal of infected teeth and tonsils may cause prompt disappearance of the ulcerative colitis" and that he "had never seen a (peptic) ulcer occur in any case in which a foci of infection could not be demonstrated as a cause".

With the exception of these two concepts, one finds the book quite practical and basic, as it is in the section on constipation. Medical therapy of gastrointestinal diseases is generally well presented.

Being entirely the work of one man, the book profits from his rich personal experience but lacks the thoroughness one finds in works by multiple authors.

C. L. Legerton, M. D.

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*Sea food—source of highly potent allergens. Typical are: lobster; tuna; sturgeon roe; fish oil used to prepare leather, chamois, soaps; cuttlefish bone for polishing material and tooth powder; glues made from fish products.



PRACTICAL REFRACTION by Bernard Gettis, M. D. Grune & Stratton, New York. 1957. Price: \$6.50.

This is a well written volume which would be of great use to any ophthalmologist. Although the subject matter includes very little in the way of new developments, the presentation is immediately impressive. As a handbook of information in brief, concise form, it will serve well as a ready reference for either the student or the busy practitioner.

This reviewer was gratified with the lucidity of Dr. Gettis' approach to this difficult subject.

G. L. Kerrison, M. D.

SURGERY IN WORLD WAR II OPHTHALMOLOGY AND OTOLARYNGOLOGY—Medical Department, United States Army, Editor-in-Chief, Col. J. B. Coates, Jr., 1957.

This book is a comprehensive report on injuries and diseases of the eye and ear encountered by the Army in World War II. The chapters are written by twenty-four contributors each with particular interest and accomplishment in his field. After several chapters on administrative aspects and clinical policies, the common affections of the eye are well described and well illustrated. The sections on visual disturbances associated with head injuries and on plastic surgery will

have a broad interest. Problems of loss of hearing are very well covered. There is an excellent chapter on facial paralysis. Every specialist in these fields should have this splendid work on his desk. The book may be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington, 25, D. C. at the nominal price of \$5.00.

F. E. Kredel

Postoperative Care of Retinal Detachment by J. W. Jerve, Jr., Greenville. Transactions of the American Ophthalmological Society, Volume LV, 1957 and reprinted in the Am. J. Ophth. 45:544-547, April 1958.

A short philosophical and eclectic approach is made to this subject with reference to 55 eyes operated for retinal detachment with 55% successful. Results of all cases, good and bad, are reported as a matter of interest and for the record. The discussion is short and to the point. Reference is made to the author's original report to the Southern Medical Association in 1951 and his work published in the Archives of Ophthalmology for January 1952, and in the American Journal of Ophthalmology for January 1953. The conclusion is reached that relative freedom in the postoperative management of retinal detachment is a sound and proper procedure.



In a recent 140-patient study¹ DIMETANE gave "more relief or was superior to other antihistamines," in 63, or 45% of a group manifesting a variety of allergic conditions. Gave good to excellent results in 87%. Was well tolerated in 92%. Only 11 patients (8%) experienced any side reactions and 5 of these could not tolerate any antihistamines.



1. Thomas, J. W.: Ann. Allergy 16:128, 1958

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The favorable record of women drivers is somewhat baffling to students of traffic fatalities, who, incidentally, are mostly men. Only the truckdriver is in her class, and he is pretty special too, if you except a few who do not really work at the trade. Though something like 10 million of the 65 million motor vehicles are trucks, they are chargeable with less than four per cent of the fatalities and less than one per cent of the injuries.

Truckdrivers, as you know, are a picked lot. Those who are in interstate commerce are re-examined every thirty-six months for signs of unfitness to drive. I should include bus drivers in this song of praise because they have an especially fine record. You are ten to twenty times as safe in a bus as in your own car. (Dorothy Noyes, in *Conn. State Med. Journ.*, March 1958)

SOCIAL SECURITY SAYS:

SOCIAL SECURITY SAYS: "A wife or widow under 62 or the divorced wife of an insured person may receive payments only while she has in her care a child (under 18 years of age) who is entitled to monthly payments."

In Other Words: Many widows who married in their 20's and lost their husbands in their 40's, would not receive any survivors' benefits until they reached age 62 because their children would be 18 or older.

Primary Tumors of the Iris. James R. Duke, M. D., Baltimore, and Shepard N. Dunn, M. D., (Columbia, S. C.) *AMA Arch. Ophth.* 59:214 (Feb. 1958)

Forty-three primary tumors of the iris examined at the Johns Hopkins Hospital over a 30 year period were reported.

Thirteen were benign melanomas, one leiomyoma, one was of uncertain histogenesis.

There were 28 malignant melanomas. All occurred in the white race. There was a higher incidence in females, an average age of 42 years, and good vision unless glaucoma had developed, which occurred in one third of the cases. Pathologically the majority of the tumors were spindle cell in type; the root of the iris was the most frequent site. Invasion of the ciliary body was common. In all but one of the enucleated eyes, tumor cells were present in the chamber angle. Iridectomy was performed in six cases and enucleation in 22 cases. Of 21 cases followed five years or longer, there was evidence of recurrence of tumor in only one patient who died from melanomatosis. There was a five year mortality rate of 4.8%, in contrast to a rate of 48% in choroidal melanomas.



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SCISSORISMS

AN EIGHTEENTH CENTURY PHYSICIAN DR. LEWIS MOTTET

This gentleman was a native of France, a man of education and a talented physician. He first settled in or near Moncks Corner, and attended the plantations both in St. John's (Berkeley) and St. James' Goose Creek, at that time probably the most genteel range of practice in South Carolina. Mottet was said to have been a *bon vivant*, and always to have looked out for good cheer, when sent for to visit a patient.

In his professional visits, he would tell the families that if a good fat calf was killed, he could extract from it something highly beneficial to his patient. That eating a loin of veal, or good calf's-head soup, strengthened his nerves, quickened his understanding, and gave him a more perfect judgment of the remedies best suited to his case. By such means he contrived to administer to his own appetites, while prescribing for his patient's relief.

On one occasion Mottet had sent in his bill against a gentleman who objected to the charges, said that it was extravagant, and refused to pay it. Mottet said nothing, made no abatement, but waited patiently until the gentleman again sent for him, having himself been attacked with a painful but not dangerous affection. Mottet went immediately, prepared to relieve him; saw the gentleman, ascertained the nature of his disease, and then very deliberately took his seat in the chamber. Being requested to do something for the relief of his patient, he said yes, he could easily relieve him; but asked, in turn, whether the gentleman had not refused to pay his bill? The gentleman acknowledged this, but now offered to pay in advance for relief from his distressing situation. Mottet still kept his seat; the patient again begged for God's sake that he would relieve him, but Mottet swore that until his last bill was paid, the gentleman should not be relieved. He was obliged to acquiesce, the money was paid, and he was promptly relieved.

On another occasion he was sent for by a dashing young gentleman, sick with intermitting fever. He inquired into the circumstances, prescribed for his patient, and left the medicines with particular directions for the taking of them. He returned the next day, a little before the time when the chilly fit was expected. But his directions had been altogether neglected—the medicine not taken—the chill had returned earlier than before, and his patient had just gone to bed with an ague. Mottet was chagrined and provoked at this neglect of his arrangements. He went up to the chamber, and finding every particular confirmed, he stripped off the bed-clothes of his patient, and gave him a smart scourging with the twig-whip, still retained in his hand. Mottet then covered up his patient carefully, and left him raging with pain and vexation.

A profuse perspiration ensued, and neither the ague nor the doctor ever returned. The young man was cured of his ague, but there was no balm applied to soothe his wounded feelings. On account of the disparity in their years, the patient resorted to the law, and sued the doctor for assault and battery. Mottet entered an appearance, attended the court, and requested permission to defend his own cause. This having been granted, he proceeded with much humor, endeavoring to make the suit ridiculous, and laugh off the penalty. He assured the court that he had only acted professionally in this case; had only executed a professional duty. That it was his duty both to prescribe and administer for the relief of his patient. That his prescriptions having been totally neglected and the paroxysm returned, he had visited him in the very crisis of the disease. That there was not a moment to spare for other remedies, such as blister, mustard plasters, and potions; even if prescribed, they also might have been rejected and neglected like the first; he was therefore obliged to administer the only remedy of which the time and circumstances admitted. He had only, in the line of his profession, applied a stimulant and rubefacient to the extremities of his patient, the application and effect of which were instantaneous, both in mind and body, and no other application could have been equally so; and he then appealed to the patient and his friends for an acknowledgment that the disease was cured from that time. Mottet spoke English imperfectly, and pretended to mistake the meaning of words both in the accusation and defence. He very gravely assured the court that the charge of "sault and batter" was altogether unfounded—that it was for a cook to use salt and batter—he was a physician, and was indignant at the imputation. The whole court was convulsed with laughter, and the doctor got off with one shilling damages.

Mottet removed from the country to Charleston, and there practiced physic about the year 1756. In 1769, he was still in practice and attended my father, in an attack of acute rheumatism. After other medicine, he administered a dose of laudanum dropped from a small phial, which he left on the mantelpiece. My father awoke in the night much relieved, but not entirely. He knew that the relief had been derived from that little phial within his reach, and concluded, if a little had done so much good, that more would cure him. He accordingly poured some of it into a wine-glass of water, probably with a heavy hand, took it, and did not awake until called upon the next day, by the doctor. Mottet looked upon the patient, still asleep, then at the phial of laudanum, and missed a large portion of what he had left in it. He awoke my father, and being told how well he felt from the second dose, he stamped and swore—cursed my father according to custom, took the laudanum and left the house.

Mottet was jealous of the well merited celebrity of Dr. Alexander Garden, and having been told that the

doctor had been complimented by Linnaeus, in calling a very beautiful plant "Gardenia,"—he said that was nothing; that he had discovered a very beautiful native plant, and had named it "Lucia," after his cook "Lucy." He did not advert to the difference between Mottet and Linnaeus.

In 1774, the name of Dr. Lewis Mottet is still seen among the residents of Charleston, and there he probably died soon after. His co-partnership with Dr. Savage expired in October, of that year.

—Johnson's *Traditions of the American Revolution*

As long ago as 1953, automobiles had claimed a greater toll of dead than all the wars in which America has engaged. I wonder what General Sherman, who spoke so feelingly of war, would say about modern traffic? It is responsible for half the peacetime deaths in the Army. The leading cause of hospitalization in the Air Force is not air crashes but automobile acci-

dents!

(Dorothy Noyes, in Conn. State Med. Journ., March 1958)

A quick, simple way to prevent most automobile accidents would be to limit licenses to women drivers and truckdrivers. Such action would bring America's No. 1 public health problem under immediate control, for these two groups show especially low accident rates.

(Dorothy Noyes, in Conn. State Med. Journ., March 1958)

How high will the social security tax go? No one knows. But in South America some countries are paying tax rates as high as 25% of payroll. In France, the tax rate is 35% of much of their payroll and is one of the principle reasons for the failure of the French economy to make a postwar comeback.



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SURGICAL MANAGEMENT OF MAJOR ARTERIAL INJURIES

EXPERIENCE WITH EIGHT CASES

BERNARD E. FERRARA, M. D. AND WILLIAM F. CAIN, M. D.

Injuries of major arteries are not unusual accidents of civilian life. Wounds inflicted by knives, icepicks, sidearms, rifles, and shotguns are usually the result of personal violence. Partial laceration, complete severance, or destruction of large segments of vessels, may be produced by these weapons. Blunt trauma, due to fractures or subluxations, can injure adjacent major vascular channels by lacerations or stretching of the vessel. Penetrating or perforating wounds produced by high velocity missiles may damage adjacent vascular or nerve structures by the wave of force, even though the nerve or vascular structure is not anatomically disrupted.^{2, 10} Sustained segmental spasm of an artery may occur in association with such local trauma or from fractures or soft tissue contusion. If the intima of the artery is injured in such a situation, a localized thrombus may form in the vessel. Complete cessation of arterial flow of necessity supervenes. If spasm alone exists, it must be relieved else arterial flow to the part will be compromised.^{1, 3, 14}

Procedure

The desideratum in the surgery of arterial trauma is to restore or maintain functioning arterial continuity. This can be done by several methods.

1. Repair of partial lacerations in the wall of the artery without resorting to ligation of the artery for control of hemorrhage.

Department of Surgery, Medical College of South Carolina and the Roper Hospital.

2. End-to-end anastomosis where arterial disruption exists.

3. Insertion of tissue grafts to bridge defects created by the injury or by the necessary debridement.

- a. Autogenous venous grafts.

- b. Preserved arterial homografts.

4. Insertion of plastic grafts.

Lateral repair of arterial wounds should be done only in instance of sharply incised wounds. Otherwise, in ragged wounds, after proper debridement has been effected, closure of the resultant defect will narrow the arterial lumen. Tangential wounds and those requiring at least moderate debridement are best treated by complete excision of the involved portion of vessel with axial suture or graft. The late results of acute arterial wounds treated by graft replacement are better with autogenous vein grafts than with arterial homografts.^{6, 7, 9}

Extensive debridement of vessel ends is not necessary as it was thought to be early in the Korean War experience.^{6, 8} Experimental evidence indicates that in bullet wounds, microscopic intimal damage extends only several millimeters beyond the grossly damaged intima. However, intimal damage is more extensive than external visible injury of the vessel.¹⁰

Tension on the suture line must be avoided. Where it exists, correction by interposition of a graft is preferable to direct vessel suture. Elimination of this factor should improve the

final results by reducing the incidence of late thrombosis at the suture line.

Adjunctive measures include sympathectomy, particularly when arterial ligation is necessary or when thrombosis of an artery to an extremity occurs, and restoration of arterial flow is impossible. Sympathetic nerve blocks are temporarily efficacious. They should never be used as replacement for proper surgical treatment. Heparin solution is valuable in preventing thrombosis distal to the site of surgical repair. A solution of 10-25 mg. per 500 ml. of normal saline is used. Varying amounts of this solution are injected into the artery at the time of surgery. Parenteral anticoagulants are seldom necessary.

If restoration of continuity is at all possible, arterial ligation should be avoided. The rapidity with which blood flow is re-established will influence the survival of the part supplied by the artery. It has been demonstrated that the incidence of gangrene increases markedly if repair is delayed beyond a time estimated at 9 to 13 hours by various authors.^{7, 8, 13}

An adequate supply of whole blood is a necessity in successful repair of most arterial injuries, since the amount required for replacement of the existing loss coupled with that needed to replace the amount lost during the procedure may prove to be considerable.

Restoration and maintenance of effective blood volume is requisite. Secondly, vasoconstriction due to hypovolemia may influence survival of an extremity, the blood supply of which has been compromised before repair.¹³

Repair and anastomosis may be accomplished successfully by a number of different types of suture techniques. Assuming that ordinary skill is utilized, one method is as successful as another. The continuous over-and-over stitch is simple and can be performed expeditiously. (Figure 1)

Number 5-0 arterial silk on an atraumatic needle was used for all repairs in our cases. Lateral suture was accomplished usually with a continuous over-and-over stitch. The vessel wall was everted minimally, so as not to narrow the arterial lumen. Anastomoses were performed by placing equidistantly two or three mattress stay sutures, the long ends of which

were run as continuous over-and-over sutures between the stays and then tied. (Figure 1)

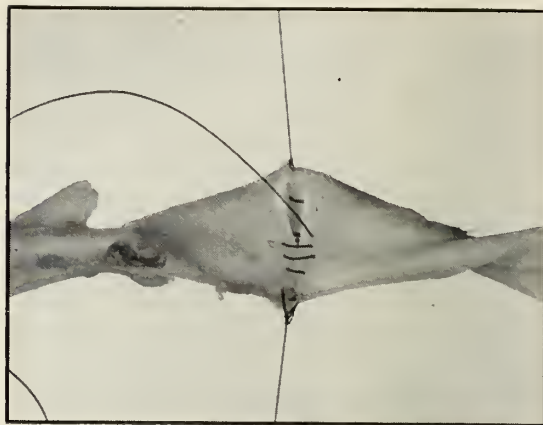


FIGURE 1

Demonstration of technique of arterial anastomosis, with artery obtained from autopsy. Stay sutures have been placed equidistantly in the vessel wall. One side of the anastomosis has been completed. The vessel is twisted by the two stay sutures, so that the final side of the anastomosis can be completed.

Hemorrhage during operation is controlled by digital pressure over the laceration until control of the vessel proximal and distal to the site of injury is obtained. This is effected by a number of occluding devices. (Figure 2) Occlusion of all tributaries in the region is necessary if a bloodless field is to be obtained. Adequate exposure, through well planned inci-



FIGURE 2

Methods of occluding vessel while repair is being accomplished. (Above) Double loop of umbilical tape (Penrose drain or Carrel tubing equally satisfactory) steadied by hemostat. Non crushing arterial clamp. (See Figure 2A) Bulldog clamp. Single loop of umbilical tape passed through rubber tubing. Artery is compressed by the tubing, which is maintained in desired position by clamping the ends of the tape.



FIGURE 2A

sions, is mandatory. The anatomy of the region should be familiar to the surgeon. Special instruments, if available, are helpful but not necessary. (Figure 3)

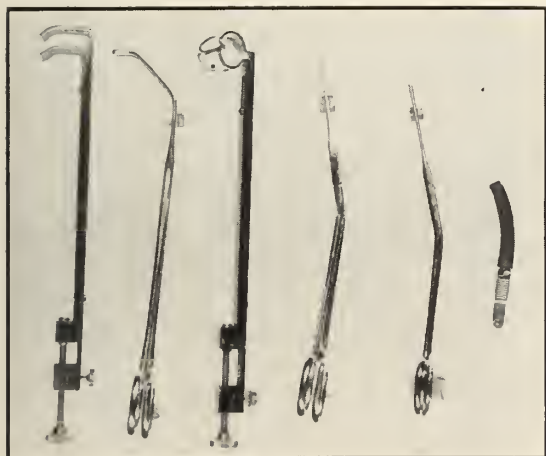


FIGURE 3

Special instruments which are helpful in arterial surgery. From left to right: Blalock pulmonic stenosis clamp, Satinsky arterial clamp, Modified Potts partial occlusion clamp, Potts patent ductus clamp, DeBakey coarctation clamp, Johns Hopkins bulldog clamp.

Indications for Surgical Exploration

In our experience, the indications for exploration of acute arterial injuries are as follows:

1. A wound in the region of a major vessel, when shock and major hemorrhage have occurred.

2. A wound in the region of a major vessel with expanding hematoma.

3. A wound near a major vessel with or without severe hemorrhage or expanding hematoma when the distal pulse is absent or diminished when compared to the other side (to obviate the error that shock might produce).

4. Blunt trauma without penetration with either a cold or a pulseless extremity, with or without hematoma.

5. Buckshot wounds if penetrating to the depth of major vessels.

When any of the above indications for operation exist, surgical treatment should not be delayed. Procrastination invites the later development of true and false aneurysms and arterio-venous fistulae. The swelling, pain, and compression of the aneurysm and the additional circulatory disturbances of the fistula should always be avoided. Whenever an arterial wound is present which is unsuspected and untreated, death from exsanguination threatens. When a reasonable possibility exists that a major arterial channel is injured, operation is indicated. It should be abundantly clear that the treatment of these injuries falls within the province of the general surgeon who maintains a continuing interest in the treatment of such cases.⁴

Case Reports

We are reporting our experience with eight cases of major arterial injuries which were seen at Roper Hospital and operated upon by the senior author. Table I shows the location and eventual outcome of the injuries. There was one death in this group.

Two patients were not seen initially. Each of these had developed false aneurysms from the original injury and were treated at Roper Hospital for the secondary complications of the injury. The other six patients were examined and treated shortly after the infliction of the wound. Only one of these six patients was not operated upon in the immediate post-injury phase. This was Case 6, a shotgun wound of the popliteal area with scatter of shot and without a confluent area of skin destruction. In retrospect, early operation should have been performed.

TABLE I

Case No.	Etiology	Location	Type of Repair	Time of Treatment	Result of Repair	Final Result
1	Buckshot	Axillary and Brachial	Lateral Suture	Initial Wound	Good	Recovered
2	Knife	Common Carotid	Lateral Suture	Initial Wound	Good	Recovered
3	Bullet	Internal Carotid	Axial Anastomosis	Initial Wound	Good	Recovered
4	Bullet	Common Femoral	Axial Anastomosis	Initial Wound	Clot distal to anastomosis	Died
5	Knife	Brachial	Axial Anastomosis	False Aneurysm	Good	Recovered
6	Buckshot	Popliteal	Lateral Suture	Arteriovenous Fistula	Infection Requiring Ligation	Recovered
7	Bullet	Axillary	Graft	False Aneurysm	Good	Recovered
8	Buckshot	Axillary	Axial Anastomosis	Initial Wound	Good	Recovered

Case 1: A 37 year old male was admitted to the hospital with a buckshot wound of the left shoulder. There was a large hematoma over the shoulder, anterior chest wall, and upper arm. Subcutaneous emphysema was present in the left supraclavicular area. No radial pulse was palpable initially, and the left upper extremity was almost completely paralysed. Chest roentgenogram demonstrated pneumothorax on the left side.

After receiving dextran and blood, he recovered from shock. The blood pressure stabilized at about 100/70 and the radial pulse became palpable. Pleural air was removed by thoracentesis. Bleeding into the dressing was continually present. At operation a 16 x 8 cm. area of devitalized skin was excised. The left arm, axilla, and posterior triangle of the neck were explored and showed four perforations of the axillary artery, one of the brachial artery, and multiple wounds of the axillary and brachial veins. There was considerable hemorrhage in the pectoral muscles and in the fascial sheath of the brachial plexus.

After hemorrhage was controlled, the perforations in the axillary and brachial arteries were closed with continuous over-and-over 5-0 arterial silk. The brachial vein was ligated. One pellet was removed from the brachial plexus. Nearly five liters of blood were administered during the procedure, which lasted two hours and forty-five minutes. Postoperatively there was progressive improvement in the use of the arm. A split-thickness skin graft was applied to the defect over the shoulder and axilla on the 15th postoperative

day and the patient was discharged (three weeks following admission).

Comment: Although the radial pulse was present preoperatively, it was necessary to explore this wound, because of the massive bleeding into the pectoral muscles and to the exterior. Without exploration and suture of the arterial and venous wounds, conditions favorable for the development of a false aneurysm and arterio-venous fistulae would have been left unattended. (Cases 5 and 7 are examples of the former and Case 6 of the latter.) Suture of the multiple sites of injury was done since no large area of the artery was badly destroyed.

Case 2: A 20 year old male was admitted with a stab wound of the left side of the neck just below the angle of the mandible. He was bleeding profusely from the wound and there was a large hematoma in the neck. Initially the blood pressure was 80/40. Following the administration of dextran it rose to 100/70. The sensorium was depressed. Exploration was carried out through an incision along the anterior border of the sternomastoid. Approximately .5 cm. below the bifurcation of the carotid, there was a .75 cm. laceration of the common carotid artery. The jugular vein was intact, as was the vagus nerve. The common, external, and internal carotid arteries were circled with tapes and the wound was repaired expeditiously. The postoperative course was smooth, and the patient was discharged eight days following admission. There was no hemiparesis and no interference with the level of consciousness.

Case 3: A 15 year old male was admitted about thirty minutes following a gun shot wound to the left side of the face with a .25 caliber bullet. His blood pressure was 116/60. He was stuporous and restless initially. His level of consciousness fell progressively. A wound of entrance was present on the left cheek lateral to the angle of the mouth and marked swelling was present on the left side of the neck and in the sublingual area. There was no respiratory obstruction and the patient moved all extremities. The neck was explored under endotracheal anesthesia. Distal to the bifurcation of the common carotid artery, the internal carotid was severely damaged and almost completely severed. Hemorrhage was controlled temporarily by finger tamponade. The internal and external carotid arteries were dissected and the external carotid artery was ligated and divided to provide exposure and mobility of the common carotid. Blalock clamps were placed on the common carotid artery proximally and on the internal carotid artery distally, and the injured segment, measuring about 1.5 cm., was excised. End-to-end anastomosis was then accomplished. A liter of blood was administered during the operation, which lasted three hours and twenty-five minutes.

Within twenty-four hours following operation, the patient was alert and was moving all of his extremities. He was discharged eight days following admission, with no neurological sequelae.

Comment: In both of the foregoing cases the location of the wounds and large hematomas in proximity to the carotid artery dictated exploration. In both cases it was necessary to incur the risk of hemiplegia by occluding the internal carotid artery completely during operative repair. Fortunately, no untoward effects occurred. With the second case, the internal carotid was so extensively damaged that simple suture was impossible and therefore, excision of the segment and anastomosis were performed. Had the artery been ligated it is quite possible that hemiplegia would have occurred.

Case 4: A 23 year old male was admitted after being shot in the left femoral triangle. The wound of entrance was five cm. below the mid portion of the inguinal ligament. There was a hematoma in the femoral triangle and the blood pressure was 80/40. There was no pulse palpable in the left lower extremity, and the left extremity was cooler than the right. Considerable bleeding was occurring from the wound and this was treated by tamponade. Hemoglobin was 8 grams per 100 ml. The patient was operated upon under general endotracheal anesthesia. The external iliac artery was freed and controlled proximal to the injury. Through a long longitudinal thigh incision, the hematoma was evacuated and the femoral artery dissected. The common femoral artery was found to be almost completely divided about 1 cm. proximal to the bifurcation into the deep and superficial femorals. A segment of artery approximately 1 cm. in length at the site of laceration was excised. The vessels were approximated and sutured. Pulsation

was palpable distal to the site of anastomosis. However, the left leg and foot remained cooler than the thigh and the dorsalis pedis pulse was not palpable. Therefore, the patient was turned and an extra-peritoneal lumbar sympathectomy was performed. Although 2500 ml. of blood were administered, the patient was hypotensive throughout the procedure. Postoperatively, no pulse was palpable in the leg and the leg was still cooler than the thigh. There was some increase in skin temperature above the knee. Anticoagulant therapy with heparin was instituted. Postoperatively the blood pressure remained at shock levels. Postoperatively the volume packed cells was 37 per cent and the hemoglobin was 11.5 grams. A total of 15 ml. of urine was excreted. Exploration of the popliteal artery was being considered but the patient died suddenly twelve hours after operation. At necropsy, the anastomosis was intact with no thrombotic material in the vicinity of the anastomosis nor in the femoral artery in the thigh. Gross and microscopic appearance of the kidneys was entirely normal.

Comment: The death in this case was most likely due to hypovolemia and renal shutdown. There was no more blood available from the local blood bank than what had been administered, although efforts were being made at the time to secure donors for re-exploration. Allusion to acquisition of blood donors in this ethnic group has been made in a prior publication.⁵

Although the anastomosis in the femoral artery was intact and without thrombus, it is likely that the popliteal or tibial arteries had thrombosed. Retrograde flush with heparin solution through the dorsalis pedis and posterior tibial arteries at the ankle should be performed in such a situation thereby clearing these channels of thrombus.¹² Sympathectomy was performed, hoping to improve the collateral circulation.

Case 5: A 28 year old male received a stab wound in the right antecubital fossa four months before admission to the Roper Hospital. The wound was explored at the time of injury and no arterial laceration was noted. Seven days before admission to this hospital swelling was noted in the right antecubital fossa and this rapidly increased in size with the onset of some discomfort and transient paresthesias in the forearm and hand. The blood pressure was 120/80 in the left arm. In the right antecubital fossa there was an 10 x 11 cm. pulsatile swelling over which a systolic bruit was present. The radial pulse was weaker on this side. Several hours after admission the mass increased visibly in size. On the evening of admission, the antecubital fossa was explored through a transverse incision. The hematoma with a well organized capsule and measuring 14 x 10 x 8 cm. was evacuated. There was a laceration about 1 cm. in length in the brachial artery. The artery was freed and Potts ductus clamps placed proximally and distally to the laceration and a segment of artery about 1 cm. in length was excised. End-to-end anastomosis was performed. Heparin solution was injected into the artery distally.

By the second postoperative day, the radial pulse on the involved side was equal in volume to the contralateral side. The patient was discharged twelve days postoperatively.

Comment: The development of the pulsatile mass in the vicinity of the previous injury was indicative of an aneurysm; thus exploration was mandatory, particularly because of a rapid increase in size.¹¹ Simple suture of the laceration was impossible because the tissue at the site of injury in the arterial wall was so poor. Therefore excision of the segment and anastomosis was performed.

Case 6: A 34 year old male was seen in the accident room thirty minutes following a shotgun blast to the back of the right leg and thigh. His blood pressure was 90/60. There were multiple wounds in the posterior part of the thigh and leg, mostly in the popliteal area. The right dorsalis pedis and posterior tibial pulses were not initially palpable but became palpable three hours later.

For the first few days following admission, the patient was febrile. Minimal swelling of the leg was present. Daily paravertebral blocks were performed. On the ninth day following the accident an arterio-venous fistula was diagnosed because of a continuous murmur and a thrill over the popliteal area.

On the twenty-third day after injury operation was performed under spinal anesthesia. There were two large veins running with the popliteal artery. The more medial of the two was found to be connected to the artery by a fistula .75 cm. in length. After the vessels were occluded proximally and distally and dissection of the vessels carried out, the fistula was divided. Defects in the vessels were closed with 5-0 arterial silk. Following repair good pulsation was noted in the artery. On the sixth postoperative day it became apparent that the wound was infected and it was partially opened for drainage. Four days later there was profuse bleeding from the wound. The patient was returned to the operating room for exploration. A rent 1 cm. in length was found in the artery, which was bleeding actively and was grossly necrotic for a length of 1.5 cm. The necrotic portion was excised and the artery and vein were ligated proximally and distally. Paravertebral blocks were continued and the lower extremity remained warm although there were subjective complaints of numbness. On the sixteenth day following ligation, the granulating wound was grafted with a split thickness skin graft. The patient was discharged two weeks later at which time he was ambulatory on crutches with minimal discomfort. This man was seen one year after discharge at which time he had no complaints. The leg was warm and he was at full time work as a laborer.

Comment: The possibility of arterial injury was considered at the time of admission. However, it was thought that the diminution of pulses was due to compression by hematoma from the multiple wounds. The fallacy of this reasoning was made clear by the development of the arterio-venous fistula. It would have

been better to have explored the artery at the time of admission. Perhaps the complicating infection and ultimate arterial ligation could have been avoided.

Case 7: A 49 year old Negro male received a bullet wound in the left shoulder area one month before admission. He was referred from another hospital when a pulsating swelling developed in his infraclavicular area. He had lost much of the motor function of his left arm and had noted numbness of his forearm and hand.

Examination revealed a pulsating mass below the clavicle in the infraclavicular region over which a bruit was heard and a thrill was palpable. Motor function at the elbow was lost. Minimal flexion of the fingers remained. The radial pulses were equal bilaterally. There was no venous distention in the left arm or forearm.

At operation a 6 x 7 cm. pulsating swelling of the axillary artery was found. The artery was almost completely severed and surrounded by a large false sac. The medial and lateral heads of the median nerve were stretched over the sac. The ulnar nerve was stretched and adhered to the sac infero-medially. The musculocutaneous nerve lay over the superior aspect of the false aneurysm. After the subclavian and brachial arteries were dissected free and controlled, the sac was freed and opened and clot evacuated. The artery was divided proximally and distally at points where viable arterial wall was present. A defect of 6-7 cm. was bridged with an arterial homograft. Anastomosis at each end was accomplished with three stay sutures of 5-0 silk joining these with a continuous over-and-over stitch. Heparin solution was injected in the graft and in the subclavian and brachial arteries. Postoperatively, the radial pulse was always of good volume and the patient's neurological deficit was improving at the time of discharge.

Comment: This case again illustrates that serious arterial disease may be present even though distal pulses are present. If early exploration had been performed, end-to-end anastomosis of the arterial wound could have been accomplished. The total neurological damage would have been less since his neurological troubles were attributed to stretch of the nerve trunks over the aneurysm.

Case 8: A 20 year old female was seen several hours after a self-inflicted shot gun wound of the left shoulder area. There was a 4.5 cm. wound of the left supraclavicular area with a 13 cm. wound of exit posteriorly. Some movement of the thumb and index finger was present but movement of the other fingers was lacking. The radial and brachial pulses were palpable bilaterally. Roentgenograms of the shoulder showed fractures of the clavicle and scapula.

Under general anesthesia, the wound was explored and extensively debrided. There was blood in the loose areolar tissue in the region of the median nerve where it is formed from the lateral and medial cords. The axillary artery was isolated and controlled proximally and distally to this area. When the hematoma

was incised, blood spurted from the artery at the point where it had been perforated by a pellet. The intima had split in a longitudinal direction for a distance of a .5 cm. This segment of the artery was excised. End-to-end anastomosis was performed. There was no anatomic disruption of the components of the brachial plexus. The vessels were covered with a portion of the pectoralis major and the wound was left open.

Postoperatively the patient developed causalgia in the arm and hand for which stellate ganglion blocks afforded some relief. However, she required large doses of narcotics.

One month after injury, the shoulder wound was covered with a split thickness skin graft. Two months from the time of the injury, a dorsal sympathectomy (first to fourth dorsal) was performed. Following this, relief of pain was complete. A plaster spica with the arm in abduction was worn for three months.

Even though her shoulder is unstable, the patient

has motion of the arm, forearm, and hand. She cannot abduct the shoulder. Her brachial and radial pulses were always of normal volume following the operative procedure. When last seen nine months following injury, she was cheerful, gaining weight, and was not disturbed by pain in the arm.

Comment: This is another illustration of the advantage of early exploration in arterial injuries to avoid later complications. It also illustrates that distal pulses may be present when arterial injury is present. This is the only case in the series that developed causalgia. Treatment by sympathectomy was satisfactory. In shotgun wounds, extensive debridement of all devitalized tissue is mandatory.

Summary

The treatment of arterial wounds and the indications for surgical intervention are discussed. Eight cases of major arterial injury are presented in detail.

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A CASE OF VENTRICULAR TACHYCARDIA ASSOCIATED WITH DIABETIC ACIDOSIS

JOHN P. COAN, M. D.^{*} AND WESLEY SEYMOUR, M. D.
Charleston, S. C.

As previously pointed out by many authors, ventricular tachycardia almost always occurs only in the presence of severe myocardial damage, and is rarely observed in patients whose hearts are normal clinically.¹ Most commonly this arrhythmia is associated with myocardial infarction, digitalis or quinidine intoxication, severe grades of hypertension, arteriosclerotic heart disease, complete heart block and in association with the so-called Wolff-Parkinson-White syndrome.² Armburst and Levine³ in their series of 107 cases of paroxysmal ventricular tachycardia failed to note metabolic disturbance as an etiologic agent in any instance. They did, however, note 14 cases in which no heart disease was present.

Although numerous cases of ventricular tachycardia have been reported in association with diabetes mellitus in none of these was the metabolic disorder believed to be responsible for the arrhythmia.

The following report is believed to represent a case of ventricular tachycardia precipitated by diabetic acidosis.

The patient was a 38 year old white male who was seen in the emergency room of Roper Hospital, Charleston, on May 21, 1955 at 10 A. M. He complained of chest pain and shortness of breath which he said had been present for 16 hours. On initial examination the patient was found to be extremely dyspneic, cyanotic, and appeared in considerable pain. His blood pressure was unobtainable and his heart rate was rapid and irregular. Electrocardiogram revealed frequent runs of ventricular tachycardia as shown in figure one. Nor-epinephrine in intravenous drip was immediately started in an effort to raise the patient's blood pressure. Persistent ventricular tachycardia then developed (see figure two.) At the same time, one gram of procaine amide (Pronestyl) was given over a ten minute period without change in the electrocardiogram. Nasal oxygen was started and the patient was admitted to the hospital for further diagnosis and treatment.

^{*}Now in practice in Spartanburg, S. C.

On arrival on the ward the blood pressure was noted to have risen to 140/70 mm of Hg, and it was further noted that the patient had rather typical Kussmaul breathing. During the next two hours three more grams of Pronestyl were given with no change in the rhythm but with some slowing of the rate.

In the interim a urinalysis revealed 4+ sugar and 4+ acetone and was positive for diacetic acid. Plasma acetone was 4+ in an undiluted specimen. CO₂ combining power was reported as six volumes percent and blood sugar was reported as 800 mg. per 100 ml.

The patient was immediately given 100 units of regular insulin subcutaneously and 150 units of regular insulin in 1,000 ml. of 1/6 molar sodium lactate was given intravenously over a one hour period. Following this the patient received another 500 ml. of 1/6 molar sodium lactate.

Three hours after the institution of therapy to correct his acidosis he was noted on ECG to have a normal sinus rhythm (see figure three). At that time his CO₂ combining power had risen to 14 volumes percent and his blood sugar was 540 mg. Serum acetone, undiluted, was one plus. Further measures to correct the patient's deranged metabolism were carried out without complication. Blood chemistries drawn on the morning following the patient's admission revealed a blood urea nitrogen of 21 mg. per 100 ml.; blood sugar of 132 mg.; CO₂ combining power of 60 volumes; blood chlorides of 460 mg.; serum sodium, 330 mg. (143.4 M. Eq./L.); serum potassium 13.1 mg. (3.36 M. Eq./L.)

An electrocardiogram revealed a tracing compatible with hypokalemia, but was otherwise normal. Chest roentgenogram revealed bilateral basilar pneumonitis and a history of cough, fever, and chills of several days duration prior to admission was obtained from the patient.

In addition it was found that he was a long standing diabetic and that he had omitted his usual 60 units of NPH insulin for the two days prior to admission.

In retrospect we feel that the pneumonitis was the precipitating factor in the production of the diabetic acidosis.

The patient's pneumonia responded satisfactorily to antibiotic therapy and the remaining hospital course was uneventful. An electrocardiogram on discharge was normal (figure four).

We feel this case to be unique because of the fail-

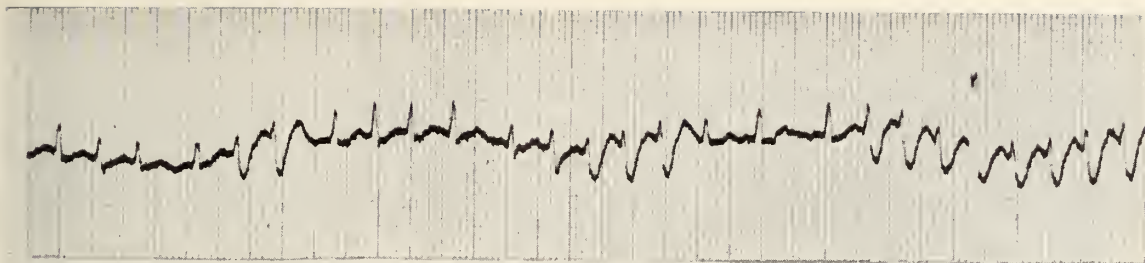


FIGURE (1)

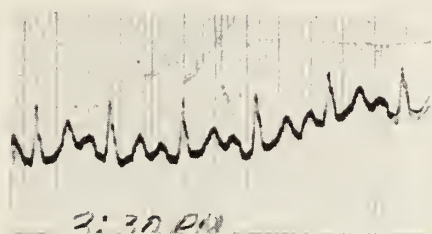
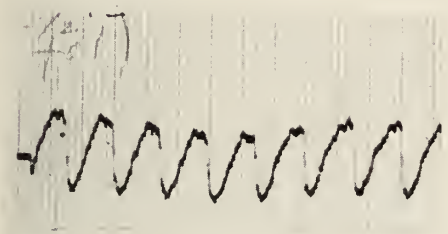
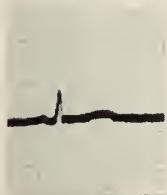
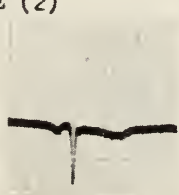


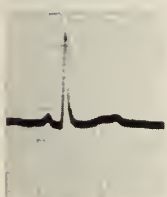
FIGURE (2)



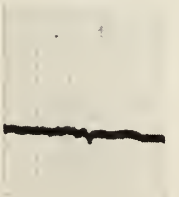
I



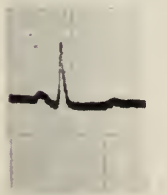
aVR



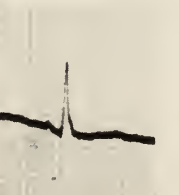
II



aVL



III

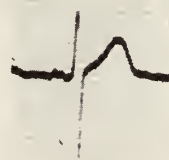


aVF

FIGURE (3)



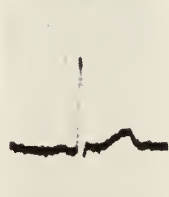
V-1



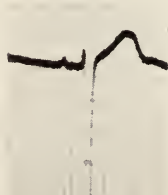
V-4



V-2



V-5



V-3



V-6'

FIGURE (4)

ure of response of the ventricular tachycardia to four grams of Pronestyl and the dramatic response to correction of the diabetic acidosis. It is postulated that both the acidosis and probable hyperkalemia were the precipitating factors of the arrhythmia and that there was no underlying organic heart disease present.

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THE TREATMENT OF VARIOUS DERMATOSES ASSOCIATED WITH DRY SKIN

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Dry skin, whether associated with other dermatoses or by itself, results from a reduction in the oil and water content of the stratum corneum.

Blank¹ shows this by placing a piece of dry, hard, cornified epithelium in water whereupon it will become soft and pliable. Softening will not take place if the callus is soaked in oil alone. However, the epithelium will dry out and harden, even if soaked in water, unless it is covered with a protective coating after it has become rehydrated. Greases and oils are effective coverings to prevent or retard the evaporation of the water.

From the clinical standpoint, dry skin presents a major problem in everyday practice. This is accentuated, particularly in the older age group, where there is modified skin physiology. Skin reactions are slower, there is a lessening of sweat and oil gland activity, and healing processes take longer. Soap and water baths are frequently poorly tolerated because they tend to remove the protective lipids of the skin. Humidity and temperature changes, particularly in the winter, further contribute to the dry skin problem.

We can determine, from the above, the following two essential requirements of a topical preparation for dry skin conditions:

1. It should contain sufficient, readily-available water for diffusion into the skin.
2. It should contain an emollient, protective agent which will retard the evaporation of the water and contribute to the softening and lubrication of the skin.

For years, we have been using various topical emollients such as petrolatum-base emulsions and hydrogenated vegetable oils. These sufficed in most of the local cases of dry skin but, in the more generalized conditions, their obvious greasiness and messiness was a serious drawback.

Recently, there has been developed a super-oiled colloidal oatmeal concentrate for use in tub baths. This powder (Aveeno "Oilated")^{*} consists of colloidal oatmeal impregnated with a mixture of 35 per cent emollient oils. The colloidal oatmeal used in this bath preparation is the special starch-protein complex of the oat grain extensively used in the preparation of colloid baths for the relief of irritated and pruritic skin conditions.

When this super-oiled colloidal oatmeal concentrate is added to the bath water a suspension of the colloidal oatmeal and a partially emulsified mixture of the oils with the bath water is formed. The colloidal oatmeal soothes the pruritus or irritated skin and the oils act to provide lubricating, emollient quality.

This new colloidal emollient bath preparation was employed in a series of 135 patients manifesting dry skin, which, in 87 patients, was associated with other types of dermatoses. In the remaining 48 patients, there was dry skin without any visible lesions.

The bath regimen was used as an adjunctive measure in these cases and, in the opinion of the observer, reduced treatment time and provided considerable subjective improvement.

^{*}Aveeno "Oilated" is manufactured by Aveeno Corporation, 250 West 57th Street, New York 19, N. Y.

TABLE 1*

Disease	Total	Good Response	No Response
Allergic Dermatitis	8	8	
Atopic Dermatitis	12	11	1
Exfoliative Dermatitis	12	12	
Hand Eczema (used as soak)	18	18	
Pityriasis Rosea	9	7	2
Psoriasis	11	11	
Senile Pruritus	17	17	
Xeroderma (dry skin)	48	48	
	135	132	3

*Dr. R. C. V. Robinson of Baltimore, Maryland, kindly gave permission to include his cases in this report.

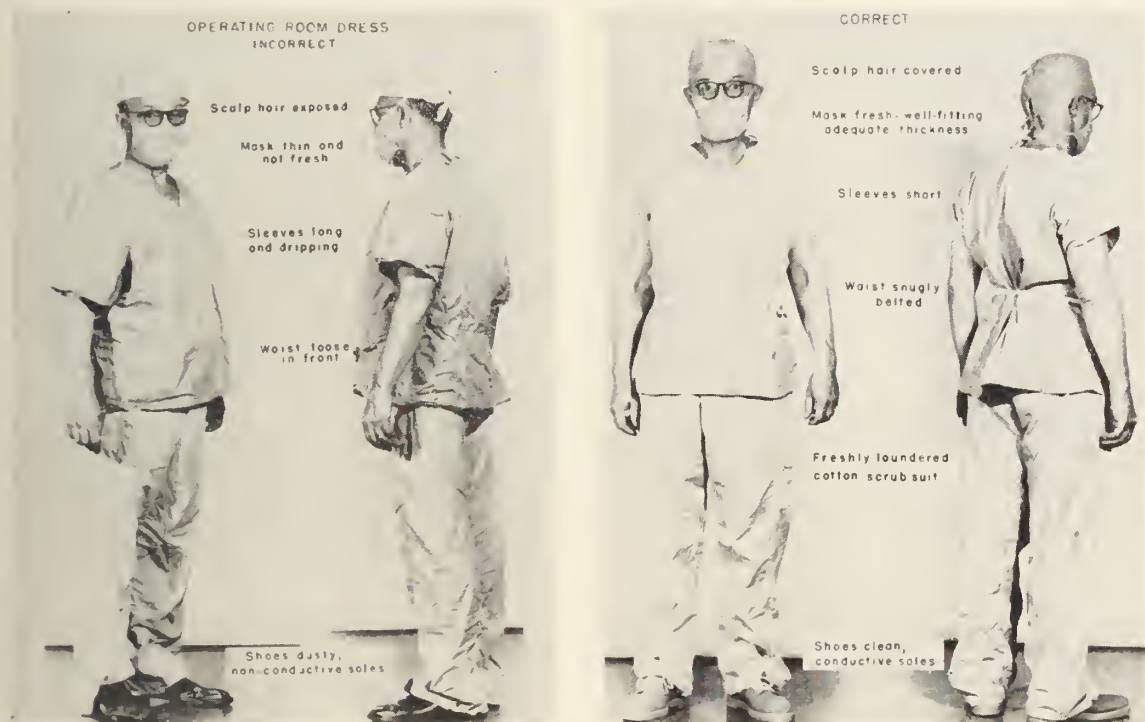
Conclusion

Baths and soaks prepared with a super-oiled

colloidal oatmeal concentrate were used in a series of 81 patients exhibiting various dry skin conditions. These modalities proved to be excellent supportive therapeutic measures since most patients improved satisfactorily. In addition, the colloidal emollient bathing procedures were easy to use and pleasant from the cosmetic standpoint. These baths and soaks have a wide indication because of their degree of safety and good adjunctive therapeutic effect.

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CARELESS OPERATING DRESS A POSSIBLE SOURCE OF CONTAMINATION

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There is considerable concern over the reported outbreaks of infections in hospitals due to antibiotic-resistant strains of organisms, particularly staphylococcus aureus. As a result, intensive efforts are being directed toward preventing cross contamination. While nurseries and obstetrical departments have been most often affected, other departments have

not been free of trouble. An infection in any one area is a source of danger to the whole hospital. As a preventative measure, technical procedures and housekeeping practices are being carefully scrutinized in all departments. The above illustration portrays possible sources of contamination due to carelessness in surgical dress.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Left Bundle Branch Block (and first degree A-V block)

DALE GROOM, M. D.
Department of Medicine

Case record—This electrocardiogram was recorded on a 64 year old lady who underwent surgery for an oral malignancy. In addition to her operative diagnosis she had hypertension (group II), known to be of many years' standing, and minimal aortic stenosis and mitral insufficiency, probably associated with her history of rheumatic disease in childhood. For several years she had taken digitalis to control the dyspnea and orthopnea of congestive failure. More recently the patient had experienced symptoms of coronary disease: pain in the mid-chest, radiating into the neck, occurring on exertion and promptly relieved by rest and nitroglycerin.

A moderate degree of left ventricular enlargement was evident in the patient's chest roentgenogram.

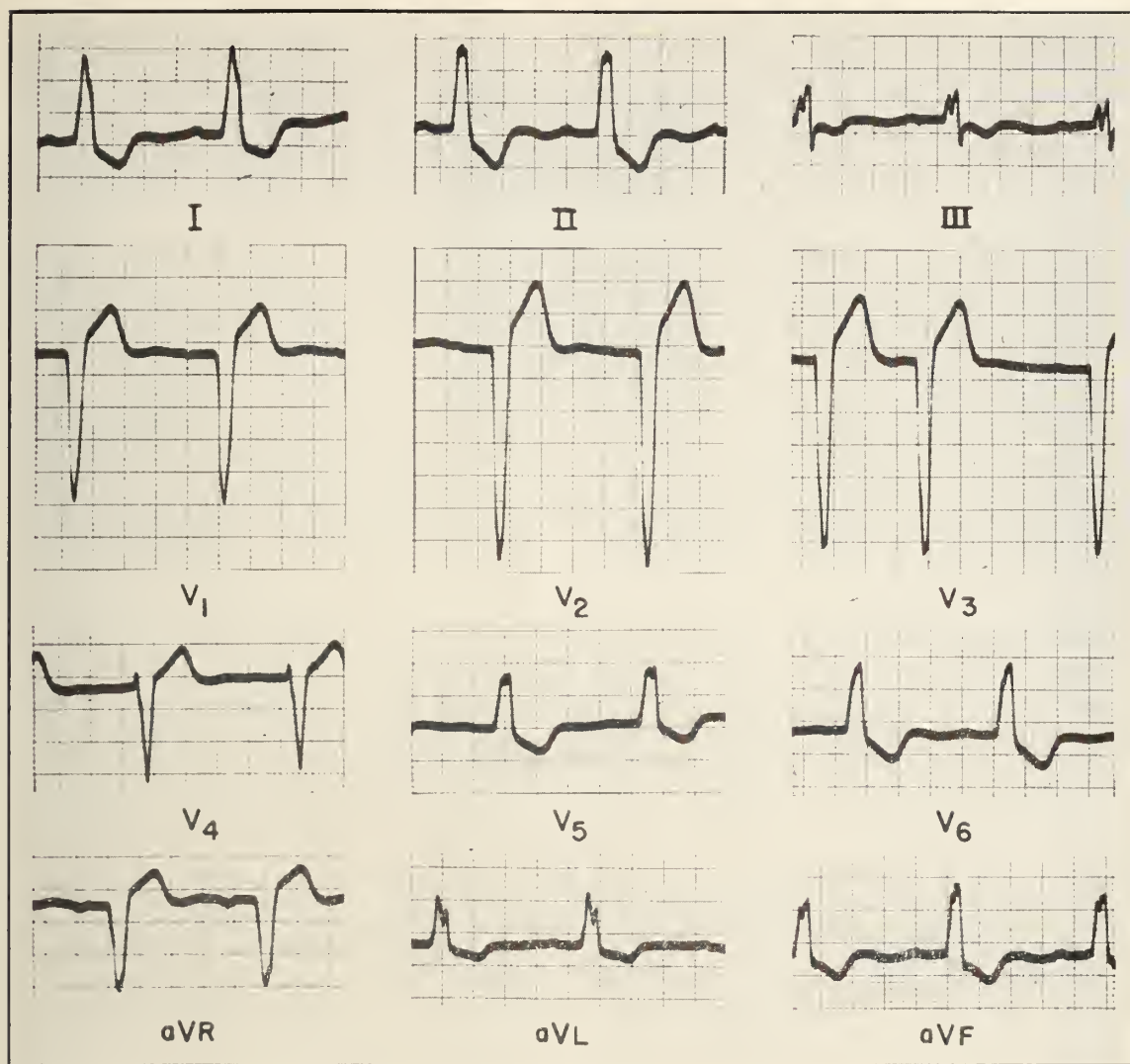
Electrocardiogram—There is a regular sinus rhythm with first degree atrioventricular block (P-R interval 0.24 sec.) and one premature contraction which is observed in V_3 as a supraventricular ectopic beat. All QRS complexes are abnormally wide and either notched or slurred. The interval from onset to end of the QRS in most leads measures 0.12 sec. A little more than 0.08 sec. is required for complete activation of the left ventricle as shown by the delayed intrinsicoid deflection of R waves in V_6 . The ST segments are moderately depressed over the left side of the heart, with reciprocal elevation in the right precordial leads. All T waves are in a direction opposite to that of the main deflection of their QRS complexes.

Discussion—The same considerations as to mechanism of block of a main branch of the His bundle, aberrant conduction of the ventricular excitation wave around the obstructing lesion, and consequent widening of the QRS discussed under "Right Bundle Branch Block"¹ apply equally in the case of left bundle branch block. When the interruption occurs in the left branch, however, it is the larger mass of ventricular muscle which is activated late because the impulse must travel around the block, presumably down the intact right bundle and thence from the right ventricle to the left. Such a devious course of activation prolongs the total time of ventricular depolarization and produces wide and variously slurred or notched QRS complexes which resemble those of

ventricular ectopic beats arising in the right side of the heart. Specifically, activation of the left ventricle is delayed, the intrinsicoid deflection of the R wave in representative leads over the left ventricle occurring 0.08 sec. or more after onset of the QRS in complete left bundle branch block. This prolongation of ventricular activation time is a requisite for the diagnosis.

As in the case of a block in the right bundle, one in the left may be complete (QRS 0.12 sec. or more) or incomplete (0.10 - 0.12 sec.), intermittent or permanent. Likewise the process of repolarization is altered by the aberrant course of depolarization, with similar results: inversion of T waves and, often, depression of ST segments in leads over the side of the heart which is blocked. Because the small branch of conduction tissue which normally activates the interventricular septum from left to right arises from the left bundle branch, interruption of this bundle reverses the direction of septal activation. Absence of the familiar Q waves in V_6 is therefore characteristic of left bundle branch block. What usually is recorded in this lead, depending of course upon the electrical position of the heart, is an initial R wave from the septum, followed by a downward deflection (which may be only a notch) caused by normal activation of the right ventricle in a direction away from the electrode, followed by an R' wave which may reach very high proportions because this potential of depolarization in the left ventricle occurs late, unopposed by that of the right. The same potential may produce deflections of even greater magnitude, though of opposite polarity, in the right precordial leads as illustrated here.

Hypertrophy of the left ventricle frequently resembles left bundle branch block in the routine twelve lead electrocardiogram. Furthermore presence of the block obscures the characteristic changes of hypertrophy. Helpful guideposts in the differential diagnosis between these two conditions may be found in the shorter QRS interval of hypertrophy (usually less than 0.12 sec.), the lesser delay of activation in leads over the left ventricle where the intrinsicoid deflection occurs earlier than 0.08 sec., absence of the slurred or notched or double spiked $R_{sR'}$ complexes in these leads and the presence of septal Q waves which indicate an intact left bundle. Some of the same features may at times be useful in differentiating left bundle branch block from other conditions which widen the QRS, such as, arborization or "peri-infarction" block, hyperkalemia, abnormalities produced by quinidine or procaine-amide, and the Wolff-Parkinson-White syndrome. Again as



in right bundle branch block, it is important to determine that the impulses are being conducted to the A-V node and the bundle branches, for a series of ectopic beats arising in a ventricle may produce ventricular complexes indistinguishable from those of bundle branch block.

A common dilemma in electrocardiography is the inability to make a diagnosis of myocardial infarction in the presence of left bundle branch block. Even though the block itself may be a manifestation of infarction, this diagnosis is always a precarious one when the left bundle is interrupted. Nearly all infarctions involve primarily the left ventricular musculature, and inasmuch as our present criteria for electrocardiographic diagnosis of infarction are based largely upon activation of that ventricle along its normal conduction pathways and in a direction from the endocardium outward, an aberrant route of

excitation nullifies these criteria. On the one hand, it masks the characteristic electrical changes of infarction, and on the other it often simulates infarction when none is present. An example of the latter is the absence of R waves and elevation of ST segments in the right precordial leads of this patient's tracing, reminiscent of acute anterior wall infarction but actually a common manifestation of left bundle branch block itself.

Nevertheless, some clues of infarction do show through the conduction defect at times. A reversal of the ST and T wave abnormalities of left bundle branch block, such as elevation of ST segments in the left precordial leads, suggests myocardial involvement. The same may be true of Q waves which extend throughout the left precordial leads. Instances have been described of premature ectopic beats arising in

the blocked ventricle "unmasking" infarction by producing the revealing Q, ST, and T wave changes which would be present were the left bundle intact. But more reliable than any single tracing in the diagnosis of infarction are serial electrocardiograms which show progressive changes indicative of an acute process.

Of the numerous causes for left bundle branch block, which may be due to either a physiologic or a pathologic change in the conduction tissue, coronary artery disease probably ranks first. Any disease which imposes stress on the left ventricle and gives rise to left ventricular hypertrophy may also produce a block in the left bundle. This conduction defect is therefore commonly associated with hypertension and with aortic stenosis or insufficiency. Left bundle branch block is occasionally seen as a transient phenomenon in acute myocarditis, in severe toxic states such as uremia, in subacute endocarditis and in quinidine toxicity. It probably occurs less frequent-

ly in normal hearts and in congenital lesions of the septum than does right bundle branch block. Its significance as a manifestation of myocardial ischemia and infarction is emphasized by its occasional appearance during an exercise test for coronary insufficiency and during attacks of angina pectoris. In most instances the block is a permanent manifestation of serious organic disease.

Much has been written of the prognosis in left bundle branch block. Follow-up studies have indicated that patients with this conduction defect have a shorter average life expectancy than do those with a block of the right bundle. But there are many notable exceptions, and the block itself is entirely compatible with adequate circulatory function. The prognosis of bundle branch block is the prognosis of the underlying heart disease.

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Duodenostomy in Gastric Resection for Duodenal Ulcer. K. M. Lippert and H. V. Coleman, (Columbia). *Am. J. Surg.* 95:781 (May 1958)

Leakage from the duodenal stump is the cause of extremely morbid and often fatal peritonitis. Extensive dissection of the duodenum, especially in penetrating ulcers, frequently leads to pancreatitis, sometimes mild but not infrequently of a severe necrotizing degree. Whether the pancreatitis causes the dissolution of the suture line or is secondary to duodenal leak is difficult to say. We feel certain that in some instances injured pancreatic and biliary ducts are responsible for some duodenal breakdowns. A method of catheter duodenostomy is described which is simple to perform with no greater complications to postoperative management than T-tube choledochostomy. Twenty-one cases of catheter duodenostomy are summarized.

These duodenostomies were performed in a series of 167 unselected gastric resections for duodenal ulcer when it appeared that a safe closure of the duodenal opening could not be accomplished. The mortality rate for the entire series of resections is 2.9 per cent. No deaths occurred among the patients who underwent duodenostomy and there were no permanent fistulas. The only complication has been an occasional localized infection of the abdominal wall at the drainage site. It is our opinion that the low morbidity and death rate in this series of operations performed on unselected patients with complicated duodenal ulcer are definitely related to the use of duodenostomy when duodenal closure is insecure or very difficult. We do not believe that duodenostomy in this group of patients has significantly prolonged the period for which they require medical treatment postoperatively.



PRESIDENT'S PAGE

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Doctors are important people in their communities and the weight of responsibility to fellowman hangs heavily on their shoulders. In their relationships with patients, with colleagues, and with the public they should maintain under God the most inflexible standards of personal honor.

As was said by Hippocrates, "A doctor should be modest, sober, patient, prompt to do his whole duty; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life." His prime responsibility should be the treatment of disease and relief of suffering regardless of pecuniary reward. Never should he promise medical cures, boast of cures or extraordinary skill and success, or criticize adversely the work or skill of any predecessor he may have had in the treatment of a patient.

If a physician is doubtful about whether a project aimed at health education of the public he may be asked to participate in is ethical he should consult his medical society or the committee or officer designated for this purpose. An ethical physician should never assist others in evading laws regulating the practice of medicine.

Good public relations should be uppermost in the minds of all physicians. Kind, frank discussion, with the patient, of his problems and the way in which you are handling the management of his case is a source of great satisfaction to him and is always genuinely appreciated. Talking over fees before treatment begins always creates a better understanding between the doctor and his patient. This is the time for adjustment rather than having a misunderstanding after the treatment is over. Friendly greetings and stopping a few moments whenever you have time to discuss subjects other than his ailments is a source of great satisfaction and demonstrates to him your interest in the welfare and livelihood of the community as a whole.

R. L. Crawford, M. D.

President, South Carolina Medical Association

Editorials

AFTERMATH OF GERMAN MEASLES

The presence of large numbers of cases of German measles in many parts of the state during the past few months brings to mind the possibly unfortunate results of the current pregnancies of women who may have contracted the disease in the first trimester. While the fact seems well established that the risk to the foetus must be considered as real, recent evaluation of the older statistics and the results of new studies seem to point to a much lower estimate of the dangers than was accepted earlier.

When the dangers of rubella were first recognized, there was a considerable amount of rather hysterical concern over the situation, so that therapeutic abortions were often requested even when a pregnant woman had been only exposed to the disease. Figures for probability of foetal damage were extremely high, and prospective mothers avoided all spotty diseases as they would the plague.

Rubella still presents a considerable risk to the prepartal woman, but new figures for incidence of foetal deformity are encouragingly low. Studies done on a group of women who had rubella early in pregnancy, during the dangerous first trimester, indicate that only three per cent of their liveborn offspring had congenital malformations, while three per cent of the foetuses were stillborn and 12 per cent were nonviable. Even when rubella occurred in the first trimester there were only 9.7% of malformed infants among those who were viable. Another study now in progress showed as its first report only four per cent of anomalies in foetuses obtained by abortion of mothers who had had rubella, and no gross cardiac damage.

In view of the accepted risk to the foetus, it would be wise to follow the advice often given to expose young girls and unpregnant women to German measles whenever it comes around, and save them (with reasonable certainty) from later infection in a more vulnerable state.

SUNTAN PILLS FOR PALE PEOPLE

A recent rash of publicity touts the use of 8-methoxypsoralen by mouth to stimulate the pigment cells of the skin into producing an increased amount of tanning of the skin and thereby allow more exposure to the burning rays of our summer sun. The drug is not new (Carolina dermatologists have been using it for at least five years in the treatment of vitiligo with some good effect) nor is the application for suntanning new. The dermatologists of one large city above the border, too busy to do much sun worshipping, have for some years been popping one of these pills into their mouths before the weekend round of golf. They found that their tanning was augmented and speeded up.

But, as with all blessings, there is one serious drawback and herewith we must add a word of caution. The sensitivity of the skin to the ultraviolet portion of sunlight is enhanced by the drug and it is much, much easier to burn the skin most severely if slight overexposure to the sun occurs before the tanning is sufficient to be protective. Already this season, several rather serious burns have been treated in the office, one requiring corticosteroid control of the inflammation.

As early as the thirteenth century, European doctors were using the Egyptian weed, *Ammi Majus* for the treatment of vitiligo, a disease in which patchy areas of arrested pigment-cell activity cause unsightly whitening of the skin. Probably many centuries before this, the Egyptian peasant chewed the rather bitter weed, in toto, to obtain the same effects. Egyptian scientists Shady and Fahmy in the 1940's isolated the chemical formula of this natural substance and it has been available in this country to qualified investigators since 1953. It may be taken internally and may also be used (with even greater caution) topically. Up to the present time, no toxic effects internally have been reported.

Many outdoor occupations require excessive exposure to sunlight. Some of us, either of

North-European stock with blond skins, or those of us born with a lack of tanning ability, but finding ourselves necessarily exposed to the sun a great deal, may benefit from the protective tanning provided by the careful use of this drug. Farmers, sailors, and fishermen with a susceptibility to sunburn, often find themselves, after years in the open, developing keratoses and skin cancers in their prematurely aged weatherbeaten skins. It is probable that a good protective pigmentation might help to prevent this, although recent studies are assigning an important role to the increased thickness of the horny outer layers of the skin as a protection. It is believed that this increase in thickness results from ultraviolet and other physical stimulation of the basal germinating layer of the skin.

Be all this as it may, perhaps these pills will prove to be a great blessing to the occasional as well as the habitual sun-worshipper if cautious exposure to the sun in the early stages of tanning is observed. The ancient Biblical injunction to moderation applies here as well as in other fields. So swallow, sun, and be happy.

J. M. Van de Erve

LEST WE FORGET

Chapter VI, Section 3 (Services to Patient of Another Physician) 1955 edition of the Principles of Medical Ethics.

A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has re-

linquished the case or has been formally dismissed.

Chapter VI, Section 4 (Criticism to be Avoided) 1955 edition of the Principles of Medical Ethics.

When a physician does not succeed another physician in charge of a case he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

SPARE THE NEEDLE

A four-in-one preparation designed to immunize children against poliomyelitis, whooping cough, diphtheria and tetanus has been tested successfully in approximately 300 Detroit children, according to an article in the June 28 issue of the Journal of the American Medical Association.

Children who participated in the study ranged in age from 2½ months to 5 years. Seventy-five per cent, or 224 of them, completed the series of three monthly inoculations, and comparisons of bloods obtained before and after the inoculations showed favorable response, the article says.

The product, known by the trademark Quadrigen, is not yet available for commercial distribution. It is the result of two years' research on combining polio vaccine with a three-in-one dose, diphtheria and tetanus toxoids and whooping cough vaccine (DPT), now in general use.



BLUE CROSS . . . BLUE SHIELD



DIAGNOSTIC HOSPITAL ADMISSIONS

Our Blue Cross contracts all have a provision for special and very minimal benefits for hospital services applicable to patients admitted principally for diagnostic studies and investigation. The provision is, in fact, a sop to meet demands of certain potential subscribers and of certain hospitals. These benefits actually mean little in dollars and cents to any sub-

scriber, but in the aggregate they cost the Plan real money.

Perhaps, more important than the monetary costs, however, are the aggravations, the complaints, the correspondence, and subterfuges which the benefit gives rise to.

Blue Cross, as an organization, has no right to be critical of any individual or of any physician who

finds it more convenient to have diagnostic x-ray studies done on an in-patient basis rather than as an out-patient service. Nor can it, as an institution, find fault with the widespread practice of having x-ray studies which are not even remotely indicated in connection with the condition under treatment done simply because the patient happens to be in the hospital. The several individuals who are connected with Blue Cross, and this includes the executive management, the members of the Board of Directors, and the subscribers themselves, do have the right to question the wisdom of these practices which have become so prevalent.

It is a fact that unnecessary, unindicated, and yet frequently ordered procedures on hospital patients are a very important factor in the increasing costs of medical care in this country. These increasing costs are exerting many influences upon the whole problem of illness.

People, in order to meet the costs of illness, are turning more and more to insurance. Insurance, on the other hand, is becoming more and more expensive instead of cheaper as it should under the influence of mass demand. The insured, because he is insured, is demanding more and more hospital treatment, more and more x-ray studies, without good indications, and an ever broadening expansion of insurance benefits. The doctor, frequently, and I believe usually, without regard to the insurance status of the patient, but under the pressure of a demanding but inadequately informed public, is allowing himself to order more and more diagnostic studies, especially x-ray and other laboratory studies, without regard to any definite indications. It is noteworthy that so many doctors are not so willing to take and record a careful history, to make a careful and comprehensive examination, or to do or to order done, diagnostic examinations which are time consuming and which cause the patient discomfort. (I am thinking, now, specifically of proctosigmoidoscopy.)

There is also a demand, either openly expressed or implied, by the hospital, that its staff and its supporting public keep its beds filled and its facilities active. With the rapid increase in hospital beds in South Carolina, and especially with their distribution among many small community hospitals, these demands have grown. Many small hospitals are attempting to furnish facilities and services which are not economically warranted, and which, because of the relatively small supporting population, cannot be superior in quality and dependability.

As a result of these several demands, we have a situation which is unsound and ill advised, and which threatens to wreck our whole health insurance program.

Many thoughtful people are seeking a remedy. Recently the insurance commissioner of New York State refused to allow an increase in Blue Cross charges by plans in that state until a more definite and powerful effort be made by each of them to re-

duce excessive and unnecessary utilization of benefits.

Few plans now allow open and frank diagnostic hospital admissions. All plans are attempting to reduce and to control admissions which actually are diagnostic, but which are concealed by the subterfuge of an admitting diagnosis. It is being urged by many thinkers, some of whom are our own doctors, that a provision be made for coverage of out-patient diagnostic studies. Proponents believe that such coverage would remove the temptation of patients and the pressure on doctors for hospital admission for studies which could be done equally as well on out-patients.

Superficially, the proposal for coverage of out-patient x-ray and other laboratory studies, has much to commend it. Actually, it involves many difficulties. If these benefits be covered under Blue Cross as they now are, the question of the hospital practicing medicine would become more pertinent than it now is. If benefits were restricted to services rendered by hospital laboratories, the question of hospitals competing with private doctors on an almost protected monopolistic basis would be very real.

If the benefits be switched from Blue Cross coverage to coverage by Blue Shield, there would have to be an adjustment of rates between the two plans. Since Blue Cross has about twice as many members as Blue Shield, there would be a large group of Blue Cross members denied benefits which they now seek and frequently receive in one way or another after hospital admission.

Finally, so long as in-hospital x-ray and other laboratory procedures are covered under Blue Cross, as they must continue to be so long as the present almost universal arrangements exist between laboratory medical personnel and employing hospitals, it seems not to be feasible to divide the coverage and benefits between Blue Cross and Blue Shield.

The present administrative problems in attempting to differentiate between *bona fide* hospital admissions primarily for needed hospital treatment of disease and those which are primarily for diagnostic studies, would be eased greatly if the large body of doctors were more frank and more explicit with their patients, with the hospitals, and with the Plan. It is not infrequent that we receive a protest like this. The admission was not diagnostic, because I knew already that the patient had an ulcer. What I wanted to know was how it was getting along. Often, the doctor protests that an admission was for diagnosis and for treatment, when the patient was kept in hospital only a day or two or three—just long enough to have the diagnostic work done. Too frequently these admissions for diagnosis and treatment are in connection with the investigation of a symptom of long standing or an acute episode which is already resolved.

Equally as serious and as costly an administrative problem occurs in connection with *bona fide* admissions for treatment of illness, when x-ray and other laboratory studies are ordered which have, or which

appear to have, no significant connection with the illness treated. Far too often, a large hospital bill is run up in connection with a relatively minor symptom or complaint. Far too often, or so it seems to many Blue Cross medical advisers, the value of a therapeutic test is overlooked or disregarded. When after up to \$95.00 worth of x-ray studies have been made, one comes up with a diagnosis of cardiospasm, or pectoral myalgia, or minimal spinal arthritis, or internal hemorrhoids, or hypothyroidism, it seems to the Blue Cross medical director that the significance of the symptom has been poorly evaluated, or that the diagnostic value of rather simple therapeutic measures has been disregarded, or that the impelling and laudable ambition to be a thorough doctor has been debased by thoughtlessness, ignorance, or extrinsic pressure.

J. Dechard Guess

NEWS

DR. BEACH RETIRES



On July 1, Dr. Mylnor Wilbur Beach, professor of Pediatrics at the Medical College of South Carolina retired from his position as head of the Department, of which he had been a member for 42 years. Dr. Beach is well known to the profession of the state and elsewhere as an able pediatrician, and to successive classes of students as a teacher whose courses were highly regarded.

Dr. Beach was born June 6, 1888, at Walterboro, S. C., the son of Austin Calhoun and Anna (Utsey) Beach. He was educated at Clemson College, (B.S. 1927) and The Medical College of the State of South Carolina, (M.D.) 1913. He married Maybelle Juliet McClure, July 9, 1918, and has one daughter Beverly Baine. He served an internship at Roper Hospital in 1913. He has been Chief Pediatrician there since 1920. He was an Assistant Resident at New York Nursery and Child's Hospital in 1915, Resident at Sea Side Hospital in 1916. He became Assistant in pediatrics at the Medical College in 1916; Instructor in 1920; Lecturer in 1921; Assistant Professor in 1926; and has been Professor of Pediatrics since 1926. He is a fellow of the American Academy of Pediatrics, a member of the Southern Medical Association; American Medical Association; South Carolina Medical Association; Medical Society of South Carolina; Charleston County Medical Society; South Carolina Pediatric Society. Dr. Beach served as Lieutenant in

the U.S. Navy (M.D.) from Dec. 22, 1917 until October 19, 1919. His hobbies are architecture, fishing and farming. He is the author of numerous published articles on pediatric subjects.

Dr. Beach has devoted his life to his only serious interests, the practice and teaching of pediatrics, and has created for himself a place of note in professional circles and in the recollection and respect of innumerable former students.

The U. S. Department of Health, Education and Welfare is discontinuing the use of the franking privilege for the collection of morbidity and vital records effective June 30, 1958. It is stated that this is being done in the interest of economy.

Morbidity reports, however, of certain diseases are essential for the protection of the health of the public. The South Carolina State Board of Health has developed a system for the collection of these statistics and the cards are now in print. These cards and the methods of use will be sent to you in the very near future.

In the meantime, it is urgently requested that you please report your communicable diseases to the local health departments by telephone until these cards are available.

G. E. McDaniel, M. D.
Director
Division of Disease Control

Patricia A. Carter, M. D., Charleston, announces the association of Louis E. Nesmith, M. D. in Obstetrics and Gynecology.

Weston Cook, M. D. and David Holler, M. D. announce their association in the practice of Orthopedic Surgery at 1730 Hampton Street, Columbia.

ARMY TO USE NEW POLYVALENT FLU VACCINE

During next October, all active duty Army personnel will be vaccinated with a new polyvalent influenza vaccine that protects against Asian, swine, A, A-prime and B strains. Vaccine also will be administered to all Army personnel who go on active duty up to August 1, 1959, including those in training for 30 days or more. Overseas, military dependents and civilian employees of the services and their dependents also will be treated. Dosages will be a single cc injected subcutaneously for all over 13 years of age and two subcutaneous doses of half a cc each at intervals of one week for those six through 12.

The National Library of Medicine has compiled a lengthy bibliography on staphylococcal infection, which, it is hoped, may be of value to both private and public health physicians who are engaged in combatting the increased incidence of antibiotic re-

sistant staphylococcal infection in the home, community and hospital. The bibliography will be sent at no cost on request to

National Library of Medicine
7th St. and Independence Ave., S. W.
Washington 25, D. C.

ANNOUNCEMENTS

To: Pediatricians in South Carolina
From: Hilla Sheriff, M. D., Director
Division of Maternal and Child Health
State Board of Health
Subject: Special Training in the Care of Pre-mature Infants.

The Maternal and Child Health Division of the State Board of Health announces that Institutes for Physicians and Nurses in the Care of Premature Infants at New York Hospital-Cornell Medical Center, New York City, will be repeated for the fiscal year 1958-59. These Institutes are designed for physicians and nurses in charge of hospital premature nurseries and special premature centers. A physician-nurse team from a locality is required for acceptance.

The intensive program for physicians is of two weeks duration and that for nurses is of four weeks duration (full-time). The first two weeks for nurses is given concurrently with the one for physicians.

The Institutes for the 1958-59 fiscal year are definitely scheduled to start on the following dates:

September 22, 1958
November 3, 1958
January 12, 1959
February 23, 1959
April 20, 1959.

Full details covering stipends and application procedure may be secured from my office. Applications must be filed at least two months before the beginning of each Institute.

A One-day course in Cardiac Resuscitation
October 3, 1958

Emory University School of Medicine
Atlanta, Georgia
Visiting Faculty

Dr. Paul Zoll, Beth Israel Hospital, Boston, Mass.
Dr. David S. Leighninger, Lakeside Hospital, Cleveland, Ohio

For further information write to:
Postgraduate Education
Emory University School of Medicine
69 Butler Street, SE
Atlanta 3, Georgia

The Arthritis and Rheumatism Foundation offers predoctoral, postdoctoral and senior investigatorship awards in the fundamental sciences related to arthritis

for work beginning July 1, 1959. Deadline for applications is October 31, 1958.

These awards are intended as fellowships to advance the training of young men and women of promise for an investigative or teaching career. They are not in the nature of a grant-in-aid in support of a research project.

The program provides for three awards:

- (1) *Predocctoral Fellowships* are limited to students who hold a bachelor's degree. Each applicant studying for an advanced degree must be acceptable to the individual under whom the work will be done. These Fellowships are tenable for one year, with prospect of renewal. Stipends range from \$1500 to \$3000 per year, depending upon the family responsibilities of the Fellow.
- (2) *Postdoctoral Fellowships* are limited to applicants with the degree of Doctor of Medicine, Doctor of Philosophy—or their equivalent. These Fellowships are tenable for one year, with prospect of renewal. Stipends range from \$4000 to \$6000 per year, depending upon the family responsibilities of the Fellow.
- (3) *Senior Investigator Awards* are made to candidates holding or eligible for a "faculty rank" such as Instructor or Assistant Professor (or equivalent) and who are sponsored by their institution. Stipends are from \$6000 to \$7500 per year and are tenable for five years.

A sum of \$500 will be paid to cover the laboratory expenses of each postdoctoral fellow and senior investigator. An equal sum will be paid to cover the tuition expenses of each predoctoral Fellow.

For further information and application forms, address the Medical Director, Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York 19, N. Y.

NATION'S OLDEST ESSAY CONTEST

The Trustees of America's oldest medical essay competition, the Caleb Fiske Prize of the Rhode Island Medical Society, announce as the subject for this year's dissertation "BRONCHOGENIC CARCINOMA—PREDISPOSING CAUSES". The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of \$300 is offered. Essays must be submitted by December 31, 1958.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

Urology Award—The American Urological Association offers an annual award of \$1000 (first prize of \$500, second prize \$300 and third prize \$200) for essays on the result of some clinical or laboratory research in Urology. Competition is limited to urologists who have been graduated not more than ten years,

and to hospital internes and residents doing research work in Urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Chalfonte-Haddon Hall, Atlantic City, New Jersey, April 20-23, 1959.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1958.

The Woman's Hospital in New York City is offering two courses in Obstetrics, limited to general practitioners. Each course is approved for 30 hours Category I credit by the American Academy of General Practice.

The courses are entitled "Ante-partum Care" and "The Conduct of Labor and Delivery". They will be given from October 16th-30th, 1958.

These are full time courses running for a week each. Students will be expected to work in the clinics, and in the second course they will be assigned to patients in labor whom they will assist at delivery. Either one or both courses may be elected.

Physicians interested in this Post-Graduate instruction will please address Mr. Carl P. Wright, Jr., Woman's Hospital, 141 West 109th Street, New York 25, New York and an application blank and prospectus will be forwarded.

THE FIFTY-SECOND ANNUAL MEETING
OF THE SOUTHERN MEDICAL ASSOCIATION
NEW ORLEANS — NOVEMBER 3-6, 1958
FEATURES

A Topflight Scientific Program

—Over 300 papers

—Geriatrics Symposium

—Twenty Sections

Twenty Guest Speakers

Selected Scientific Exhibits

Selected Technical Exhibits

Section Luncheons and Dinners

Four Color Television Programs

Alumni and Fraternity Reunions

35th SMA Golf Tournament

Past Presidents' Dinner

Past Councilors' Breakfast

President's Luncheon

President's Night—Annual Dinner Dance

Official Tours of the New Orleans Area

Doctors' Day Luncheon—Auxiliary

Post-Convention Tour to Mexico

AMERICAN ASSOCIATION OF MEDICAL
ASSISTANTS

Plans have been made for the Second Annual Convention of the American Association of Medical

Assistants to be held at the Palmer House, Chicago, Illinois on October 31, November 1 and 2, 1958.

The American Association of Medical Assistants is made up of men and women employed as assistants in the offices of Doctors of Medicine.

The purposes of the Association are stated as follows: To inspire its members to render honest, loyal and more efficient service to the profession and to the public which they serve. To strive at all times to cooperate with the medical profession in improving public relations. To render educational services for the self-improvement of its members.

The American Association of Medical Assistants would welcome the opportunity to give information concerning the organization and to assist with the formation of County and State Societies. Inquiries may be addressed to Miss Hallie Cummins, R.R.L., Chairman of the Public Relations Committee, Medical Record Library, Caro State Hospital for Epileptics, Caro, Michigan.

NINTH ANNUAL WINSTON-SALEM
HEART SYMPOSIUM

FRIDAY, OCTOBER 3, 1958

Ballroom—Hotel Robert E. Lee

9:00 A. M.

Presiding: Harold D. Green, M. D., Winston-Salem, N. C.

"NEWER DIAGNOSTIC TOOLS IN CARDIO-
VASCULAR DISEASE"

Moderator: James V. Warren, M. D., Durham, N. C.

Panel: George Harrell, M. D., Gainesville, Florida

Frank Damman, M. D., Charlottesville, Va.

Emory Miller, M. D., Winston-Salem, N. C.

"WHO ARE CANDIDATES FOR CARDIAC
SURGERY?"

Frank Damman, M. D.

11:15 A. M.

Intermission

11:30 A. M.

"MODERN TECHNIQUES IN CARDIAC
SURGERY"

W. Harry Muller, M. D., Charlottesville, Va.

12:30 P. M.

ANNOUNCEMENTS AND LUNCH

2:00 P. M.

Presiding: Edward Schoenheit, M. D., Asheville, N. C.

"GLUTTONY, OBESITY, AND VASCULAR
DETERIORATION"

William Parson, M. D., Charlottesville, Virginia

"SURGICAL APPROACHES TO OCCLUSIVE
PERIPHERAL VASCULAR DISEASES"

W. Harry Muller, M. D.

3:45 P. M.

Intermission

4:00 P. M. to 5:00 P. M.

"RESUSCITATION IN SUDDEN DEATH"

Moderator: William Burnett, M. D., University of N. C. School of Medicine

Panel: Leonard Nanzetta, M. D., Winston-Salem, N. C.
W. Harry Muller, M. D.
George Harrell, M. D.

6:00 P. M.

SOCIAL HOUR — Ballroom

7:00 P. M.

DINNER—Balinese Roof

(As guests of Forsyth Medical Society)

Presiding: A. J. Crutchfield, M. D.

Address: "FATS IN YOUR FUTURE"

George Harrell, M. D.

Demonstration of Flowmeter and Heart Lung
Machine—Merrill P. Spencer, M. D., Frank R.
Johnston, M. D., and Robert Cordell, M. D.

This program has been approved by the A. A. G. P.
for six and one-half hours of credits.

There is no Registration Fee.

AMA OPPOSES FORAND BILL AT HOUSE HEARINGS AS UNNECESSARY, RISKY

Testifying before the House Ways and Means Committee in June, two witnesses for the American Medical Association opposed the Forand hospitalization-surgical care amendment to the social security program as unnecessary, of unpredictable cost, and as pointing the way to a complete program of socialized medicine. Witnesses were Drs. Leonard Larson, an AMA trustee, and Frank Krusen of the Mayo Clinic.

"Today you have before you proposals which would . . . mean a federally financed and federally controlled system of medical-hospital care, first for social security beneficiaries, subsequently for other groups and ultimately for everyone," Dr. Larson said. He explained that the medical profession is "acutely aware" of existence of medical care problems among the aged, and added: "We do not agree, however, with the advocates of the pending legislation as to the nature and extent of the problems, or as to the means of solving them. We feel, as do many others, that traditional voluntary private methods can eliminate deficiencies and at the same time preserve individual and community freedom."

Dr. Larson then described in some detail new operative procedures, development of antibiotics, and other medical advances' private enterprise accomplishments that are "evidence that federal intervention is not required." Regarding medical progress and the increasing number of aged, he said, "Thus we in medicine have helped to create not only the problem of the aged, we have helped to create the aged. We have done it under the free choice system. We can solve the problems in the same way." One of the most encouraging developments, Dr. Larson said, was the remarkable growth of voluntary health insurance among the aged, an indication that still greater protection will be provided in the future without Federal action.

Dr. Krusen made it clear that the AMA has not

and is not now opposing social security, but that it has and is opposing such proposals as the Forand bill, which "represent in our opinion a major and dangerous deviation from the original concept of the system." Dr. Krusen then made these points, among others:

1. The aged, for the most part, do not need short stays in general hospitals but rather improved home and community care, "as well as less costly and improved chronic illness and nursing home facilities."

2. The AMA on its own and through the Joint Commission to Improve the Health Care of the Aged is attacking the problems of furnishing medical care to the aged, and is supporting legislation for federal mortgage guarantees for proprietary and other hospital and nursing homes to reduce costs.

3. Under the Forand bill the government would (a) finance health care of millions through compulsory taxes, (b) control the funds, (c) set benefits and rates of compensation, (d) establish and enforce hospital and medical care standards.

4. Patient and physician alike would have to submit to Federal regulations, and patients would not have free choice of physician.

5. Medical efforts alone will not solve the problems of the aged; many other segments of our society will have to contribute, as many of their ills are the direct result of the inferior role in which this group has been placed." He added: "We as physicians are going to find out what the aged really need; what new improvements are succeeding in giving them better health care and how such procedures can be universally applied."

A.M.A. Washington Letter



"CHECK MISS SAWS CARD 'RETURN VISIT, - NO CHARGE.'"

A SUMMARY OF ACTION TAKEN AT THE

Annual Convention of 1958

Abstracted from the Minutes

The House of Delegates took action on a number of items of business, of which the more important are here given.

Medicare

A proposal to abandon our contract with Medicare was considered and defeated by an ample majority. Resolutions from several county societies to the effect that anesthesiologists, pathologists, and radiologists be paid directly by Medicare were passed and such a recommendation was to be made to the administering authority.

Automobile Drivers

The Association advocated periodic examination of holders of drivers' licenses, and a minimum driving age of 16 years.

Basic Science Law

This type of law was approved and further study was to be made for final proposal.

Immunization Programs

The House approved the recommendation of the Columbia Medical Society that county societies have more regulation and control of the immunization programs of the local health departments.

Vocational Rehabilitation

It was decided that the Vocational Rehabilitation authorities be requested to allow a separate fee for surgical assistants when they are not members of a house staff.

Medical Examiners

The longstanding discussion on substituting medical

examiners for non-medical coroners was again extended for further study.

Workman's Compensation

The House expressed a desire for a review of Workmen's Compensation in respect to medical relations.

Liaison Committee with Medical College

Extended exposition of the question of establishing this committee resulted in an overwhelming vote of disapproval.

Nursing Consultant

Action was postponed on approval of a proposed nursing consultation service offered by The Duke Foundation until further investigation could be carried out by Council.

Certification of Psychologists

The Association agreed to study with the South Carolina Psychological Association the matter of certification of psychologists.

Registration of Physicians

A proposal for an annual or semiannual registration of physicians in the state was carried on for further study.

The House heard accounts of the prosecution of a naturopathic physician, and considerable discussion of the state of affairs in Blue Cross and Blue Shield business. These matters and a number of others not listed here will be found recounted in full in the complete minutes, which follow.

The next annual meeting will be in Columbia, on May 12, 13 and 14, 1959.

ONE HUNDRED AND TENTH ANNUAL SESSION OF THE SOUTH CAROLINA MEDICAL ASSOCIATION. HOUSE OF DELEGATES

MYRTLE BEACH, S. C., MAY 13TH AND 14TH, 1958, OCEAN FOREST HOTEL

Dr. D. Lesesne Smith, Presiding

The Annual Convention of the South Carolina Medical Association was held at the Ocean Forest Hotel, Myrtle Beach, South Carolina, May 13th and 14th, 1958. The President, Dr. D. Lesesne Smith, of Spartanburg, S. C., presided. The first meeting was called to order at two o'clock P. M., on May 13th, by the President.

PRESIDENT SMITH: Will the House of Delegates of the South Carolina Medical Association come to order. We will now have the invocation by the Reverend Manning Reed, Trinity Episcopal Church, Myrtle Beach.

The Invocation is given by Mr. Reed.

PRESIDENT SMITH: Gentlemen, I would like to have a report of the Credentials Committee.

DR. O. B. MAYER: Mr. Chairman, I beg to report that a quorum is present.

PRESIDENT SMITH: I now declare the session of the House open. Gentlemen, this meeting this afternoon is for the purpose of presenting resolutions, and to hear committee reports, of which there will be no discussion. Many of these reports appear in *The Journal* and many do not. We will refer these committee reports to the various reference committees, and we would like to do this work with dispatch; we have many things to do.

It is my pleasure at the outset of this meeting, not to introduce but to present to you your President-Elect, Dr. R. L. Crawford.

DR. CRAWFORD: Mr. President, and Members of the House of Delegates, I want to take this opportunity to thank you for electing me to the presidency of our great organization. It is indeed an honor for which I am grateful.

During the past year things have been relatively calm political-wise, but in this coming year after the elections the politicians will be able to give their undivided attention to legislative matters, and no doubt some legislation adverse to organized medicine, such as the Forand Bill, will arise. You will be called upon to exert your influence in it, and I hope you will respond promptly and effectively when notified. Occasionally this notification may have to be on short notice. Only in this way can we effectively combat inroads of collectivism and socialism into our free enterprise system.

PRESIDENT SMITH: Thank you, Dr. Crawford. Gentlemen, the Reference Committees appear in *The Journal* and in your programs. The names of the Reference Committees will be on the blackboard, and there will be a few changes; but we will have such notification so that you will know where these committees will be tonight.

Now gentlemen, the first order of business is to present resolutions and recommendations.

DR. WILLIAM WESTON, JR.: Mr. President, I have a resolution to present.

(1)
"Dr. Wm. Weston, Jr. stated that since the Hill-Burton Funds have taken over the construction of hospitals, the Duke Endowment Fund is giving less money for this purpose, and is therefore considering instead providing free nursing consultants to hospitals in North and South Carolina. It is necessary that this

be approved by state medical and nursing organizations before such a consultant is hired. All of the necessary organizations have now approved except the South Carolina Medical Association. Dr. Weston further explained that the individual hired would be a graduate nurse with a Masters' in Nursing, who would provide inservice nursing education, advice on hospital management, nursing management and nursing curriculum all over the state. She would be paid \$50.00 a day, plus expenses, which would come entirely from the Duke Endowment Fund."

"Dr. Henry Moore moved that the delegates of our Society be instructed to bring the matter up at the annual meeting of the South Carolina Medical Association as approved by our Society, with a request that the South Carolina Medical Association also grant its approval. Dr. Weston, Jr. seconded the motion, and it was voted on and carried in the affirmative."

I move the adoption of this resolution.

PRESIDENT SMITH: You have heard the resolution of Dr. Weston. If there is no discussion these resolutions will be referred to the Reference Committee on Public and Industrial Health.

DR. WESTON: I have another resolution.

(2)

There was lengthy discussion concerning the fact that Health Departments should work strictly in conjunction with the local medical societies in the matter of their immunization programs, and it was pointed out that this practice has not been followed in the past. A closer relationship between the Health Departments and the local medical societies would prevent conflicting recommendations from these organizations concerning such matters as whether to give three or four polio shots. It was also pointed out that immunizations are frequently given when not needed and sometimes when contra-indicated, for example, when smallpox vaccinations are given during measles and chickenpox epidemics.

Dr. John Harvin moved that the delegates of the Columbia Medical Society be instructed to propose at the Annual Meeting of the South Carolina Medical Association that the immunization programs of the public health departments be re-evaluated, pointing out that (1) local medical societies should be consulted and have jurisdiction over the immunization program of health departments, and (2) that health departments should give immunizations to indigent patients only, with patients able to pay to receive their immunizations from their local physicians.

Dr. William Weston, Jr. seconded the motion, and it was voted on and carried in the affirmative.

DR. SMITH: This will be referred to the Committee on Public Health.

DR. WALLIS D. CONE: Mr. President, I have a resolution on behalf of the Sumter-Clarendon Medical Society, which I would like to read.

WHEREAS, it seems many people want to be known as 'doctors' but few want to go to medical college, and

WHEREAS, naturopaths, consulting psychologists, chiropractors, etc., practice as legitimate members of the healing profession, and

WHEREAS, by virtue of precedent, these people are

mentally accepted as reputable members of the healing profession by a large proportion of the deluded public, and

WHEREAS, it is almost impossible to take from the members of these cults any legal privilege once granted, and

WHEREAS, a basic science law for South Carolina would scare many of these people away from our state before they ever got here, and

WHEREAS, a basic science law should work no hardship on any aspiring legitimate medical doctor, and WHEREAS, a basic science law would deal only with the basic sciences and would not interfere materially with the function of the Board of Medical Examiners, and

WHEREAS, the Sumter-Clarendon Medical Society, Incorporated, has instructed its delegates to make this recommendation to the House of Delegates with the endorsement of the Seventh District Medical Association, be it

RESOLVED, that the House of Delegates appoint a committee to investigate the desirability of instructing legal counsel to endeavor to get the South Carolina legislature to enact a basic science law.

Wallis D. Cone

Sumter-Clarendon Medical Society, Inc.

PRESIDENT SMITH: This resolution will be referred to the Committee on Legislation and Public Relations.

DR. CONE: I have another resolution, Mr. President. On behalf of the Sumter-Clarendon Medical Society, I present this resolution.

WHEREAS, a fee is paid for the medical doctor or surgeon and anesthesiologist in Vocational Rehabilitation cases and

WHEREAS, no provision is made to pay a surgical assistant a fee, be it

RESOLVED that the House of Delegates of South Carolina Medical Association recommend to the Division of Vocational Rehabilitation that they pay a surgical assistant's fee when the assistant used is a private practitioner and not an intern or resident physician.

Wallis D. Cone

Sumter-Clarendon Medical Society, Inc.

PRESIDENT SMITH: This resolution will be referred to the Committee on Miscellaneous Business.

DR. W. W. EDWARDS: Mr. President, I wish to present a resolution, which was passed by the Greenville County Medical Society.

WHEREAS, The Medical Profession has consistently opposed the assumption of the responsibility for the provision of medical care for civilians in general by the Federal Government (socialized medicine); and WHEREAS, Existing legislation (Medicare) does instruct the Federal Government to provide medical care for a large segment of the civilian population; and

WHEREAS, Proposed legislation (Forand Bill) will instruct the Federal Government to provide medical care for another large segment of the civilian population; and

WHEREAS, such Federal activities, if unchecked, will shortly lead to destruction of the private practice of medicine, which has occurred in England, recently, to the detriment of patients and physicians, and the national solvency;

Now, Therefore, be it

RESOLVED, that the South Carolina Medical Association shall not renew the Medicare Contract with the Department of Defense when this expires.

PRESIDENT SMITH: Thank you Dr. Edwards. This resolution will be referred to the Reference Committee on Insurance, Blue Cross and Blue Shield.

DR. W. W. EDWARDS: Mr. President, I have

another resolution from the Greenville County Medical Society, which I wish to present.

WHEREAS, the practice of anesthesiology, pathology and radiology is the practice of medicine; and

WHEREAS, anesthesiologic, pathologic and radiologic services may be rendered in or outside a hospital; and

WHEREAS, the Medical Society of the State of South Carolina has contracted for physicians of the State of South Carolina with the Department of Defense to supply medical services to dependents of the Uniformed Services under Public Law 569 of the 84th Congress (otherwise known as the Dependent's Medical Care Plan); and

WHEREAS, certification of medical services rendered can be made only by physicians; BE IT THEREFORE RESOLVED, That the Greenville County Medical Society hereby petitions the South Carolina Medical Association to declare that anesthesiology, pathology and radiology are medical services under the terms of the contract which has been negotiated between the Medical Association and the Department of Defense in compliance with the Dependent's Medical Care Plan and that fees for such services, whenever rendered, must be paid to the physicians rendering the services.

DR. O. B. MAYER (?): Mr. President, I wish to present a similar recommendation and resolution which was passed by the Columbia Medical Society, and I wish to make that a point of record, that the Columbia Medical Society also presents the same resolution, the same wording, and would like to have it referred to the same committee as Dr. Edwards' resolution.

An identical resolution is read.

PRESIDENT SMITH: Thank you Dr. Edwards. This too will be referred to the Reference Committee on Insurance, Blue Cross and Blue Shield.

DR. ROBERTSON: Mr. President, the Charleston County Medical Society passed a resolution that is identical with the one presented by Dr. Edwards, and I would like to add this one.

An identical resolution is read.

PRESIDENT SMITH: That will be referred to the same committee.

DR. _____: The Anderson County Medical Society would like to present the following resolution.

The Anderson County Medical Society has unanimously requested that the house of delegates of the South Carolina Medical Association take necessary steps to present legislation to the General Assembly of South Carolina for purpose of the institution of a medical examiners system patterned after that in effect in Virginia. This to replace the coroners system throughout the state.

PRESIDENT SMITH: This will be referred to the Reference Committee on Legislation and Public Relations. We would like to have a copy of your resolution.

Any further resolutions? No further resolutions or recommendations?

We will postpone the introduction of the officers of the Woman's Auxiliary until three-fifteen, to be a special order of business.

Now gentlemen, I want to give my report as President. Will Dr. Eaddy take the Chair? (Vice President, Dr. Norman O. Eaddy, assumes the Chair)

PRESIDENT SMITH: I should like to give you a brief report of my activities as your President for the past year. I attended the A. M. A. as an observer at the House of Delegates and reference committees. I represented the Association at many county society meetings as well as district meetings and addressed some of these; also the executive board of The

Woman's Auxiliary, Crippled Children Society and other allied organizations.

I would like to recommend that the meetings of the county medical society officers be held annually at our meeting on January 26th. The speakers all presented subjects helpful to the county societies and drew them closer to the State Association.

The Medical Civil Defense meeting under the leadership of Dr. Charles Wyatt, was most fruitful. Within the next year civil defense in South Carolina will be well prepared for an emergency.

Every doctor in our state has received a letter from me supporting Blue Shield.

I feel that the affairs of the Association are in good order. I would like to congratulate the officers of the House of Delegates, the Council and the various committees for their enthusiastic work for the Association and express my appreciation for their help this year.

President Smith resumes the Chair.

PRESIDENT SMITH: Now gentlemen, we will have the report of the Executive Secretary, Mr. M. L. Meadors.

REPORT OF EXECUTIVE SECRETARY AND COUNSEL

MR. MEADORS: If promptness in discharging their financial obligations to the organization is any indication, interest and satisfaction with the work of the South Carolina Medical Association on the part of its members must be at an all time high. A total of 1051 members have paid their dues for 1958, thus exceeding by some 200, the highest number ever paid prior to the annual meeting. This is more surprising in view of the fact that the dues for this year represent almost a 100% increase over those for previous years. No doubt the improvement in this respect can be traced primarily to the fact that for the first time this year statements were mailed from the Executive Office to all of the members immediately after January 1st. It had never been the custom heretofore to send statements, this matter being left entirely to the County Society Secretary. In view, however, of the increase in dues and the inclusion of the amount requested on a voluntary basis for medical education, preparation and mailing of statements this year seemed virtually necessary. In view of the results, I think it is safe to say that it will be continued annually. (In fact, judging by this it might be well to raise the dues again!)

In addition to the paying members, there are 160 Honorary members, 8 service and 9 junior members for a total at this time of 1228. This includes 26 new members.

Another factor which may have had some bearing upon the early payment of dues by the majority of the members, has been the continued strengthening of insistence on the part of the American Medical Association for early payment of their dues. By far the majority of the members pay all their obligations at the same time. In addition to the state dues collected, we have received payments for the AMA for the current year also from 1017 members. A check was mailed to Chicago on Saturday for \$19,129, which amount, added to a previous remittance of \$6,475 makes a total of \$25,000 for the current year. Of the total number of members paying State dues, approximately one-half have paid also the \$10 requested for the American Medical Education Fund. It has been interesting to note that the proportion in all sections of the State has run approximately the same, about 50-50 throughout.

The financial affairs of *The Journal* also are in excellent condition. While the cost of producing the publication continues to increase, the receipts from advertising have increased regularly also, and there

has been for the past year and a half a considerably more healthy spread between the two figures. This situation is largely due to the fine work of the State Medical Journal Advertising Bureau, a co-operative organization with headquarters in Chicago, representing 34 State Journals. All national advertising for these journals is placed through the Bureau which collects the amounts and remits to the State on a monthly basis, retaining a small percentage to defray the cost of operation. The records of our Journal show that for 1957 receipts from advertising, both national and otherwise, amounted to \$27,662, thus exceeding by about \$8,500 the cost of Journal printing and other expenses in the amount of \$19,119. Five dollars for the Permanent Home Fund has been deducted from the dues of the members as paid, and this has been placed in a separate investment account and is now drawing interest. All bills of the Association, of course, are paid regularly. Investments are in Government Bonds and savings accounts in government insured banks and Savings and Loan Associations.

A major activity of the Executive Office during the past year has been the preparation of the new directory. We regret that it was impossible for this to be completed so as to have the directories in your hands by the time of this meeting. You will recall that two years ago, they were mailed in the latter part of April. This year, as indicated above, the clerical work involved in the mailing of statements, the collection of additional funds and their segregation to various accounts, placed more than the usual burden upon the clerical staff, and we have operated with no increase in the number of assistants. That plus the fact that a large number of communities in the State have added exchanges to the telephone numbers has made it increasingly difficult to complete all of the detail work necessary for making up the directory. It is approximately nine-tenths completed. Actually, most of it has been set in type, and all of this would have been done except for the necessity of suspending work on it to prepare for this meeting. We hope that the directories can be in the mail to the members of the Association in June.

At the time of the last annual meeting, we reported to the House of Delegates that the law to repeal the Naturopathic licensing statutes had withstood the judicial tests and was firmly established as the law of the State, although some naturopaths continued to practice. It was our recommendation at that time that unless some steps were taken by the Attorney General's office to enforce the provisions of the law more rigidly, that the Governor would be contacted and requested to have the State Law Enforcement Division move in this direction. After some further delay and contacts with the State authorities, the Attorney General through the Governor's office formally requested that the Law Enforcement Division take steps. We had furnished to the Attorney General the names of several naturopaths still practicing and evidence obtained from some of their victims. A representative visited the Association offices to discuss the matter and obtain additional information. One of the most flagrant violators was a man who had practiced several years ago in Florence, within the shadow of the Association headquarters; and who since the passage of the repeal statute, had moved his scene of operations to Murrell's Inlet in Georgetown County. The Law Enforcement Division concentrated upon him and built up an excellent case. After watching his place on several occasions and, interviewing some of his patients as they left his office, the officers moved in and arrested him in the early part of this year, obtaining at the time photographs of his office, his magic diagnostic and therapeutic machine and other equipment. "Dr." Breed-

love was tried in the Court of General Sessions in Georgetown County on April 15 and found guilty of practicing naturopathy in South Carolina. He was given the maximum sentence by the presiding Judge, Honorable J. Henry Johnson, of one year in jail or a fine of \$500. He promptly paid the fine. In the interim between the time of his arrest and his trial, "Dr." Breedlove's office and most of, if not all, his equipment had been burned. We were approached prior to the trial with a request that it be deferred, statement being made that the man intended to leave the state and would not undertake to ply his trade further.

So far as we know this is the first actual test, in a criminal proceeding of the naturopathic licensing law, and we were, of course, highly pleased that it again stood the test and that a conviction has been had from which there was no appeal. The Law Enforcement Division is working on other cases, and we have no doubt that the result in this first instance will have a salutary effect. I wish to take this occasion to compliment highly to the State Law Enforcement Division of South Carolina and its representatives who worked on the case. It was well prepared, and the necessary evidence on hand to furnish the conviction. As Legal Counsel for the Association, we assisted Solicitor J. Reuben Long of the Twelfth Circuit and took active part in the procedure.

At the 1958 Session of the Legislature, not simply one but three bills to permit again the licensing of naturopaths in South Carolina were introduced in the House of Representatives. All were authored by Representative C. A. Mitchell, of Oconee County, himself a naturopath who formerly held a license and operated some sort of clinic or supposed hospital near Seneca. On the first of the bills Mr. Mitchell had other representatives as co-authors. The first two bills were referred to the Committee on Military, Public and Municipal Affairs, and the third to the Judiciary Committee of the House. Public hearings were requested but the matters never reached the state, and none of the bills received action by the Committee or were reported out. Possibly, new bills will be introduced at the next and future sessions, but we predict similar results at least for a long time to come.

The bills sponsored by the optometrists to expand their authority in the care and treatment of the eye made no progress during the recent Legislative Session. It will be recalled that last year it remained in the Judiciary Committee of the House of Representatives, and this year no determined effort was made by its sponsors to bring it out. We believe they recognized the futility of such effort at this time, but that the effort will probably be renewed in connection with a new bill next year.

The second Annual County Society Officers Meeting was held in Columbia in February. Approximately 50 County Officers were present for the luncheon which they attended as guests of the Association, and for the program which followed. Through the interested efforts of Dr. Lesesne Smith, President of the Association, an informative session was arranged. Topics discussed included collection of dues, Medical Education Fund, Public relations and legislation. Dr. Thomas Alphin, Director of the Washington Office of the American Medical Association was one of the featured speakers. We believe it was the consensus of opinion that the Annual County Society Officers meeting serves a useful purpose, and we recommend that it be continued.

Last September at the request and with the cooperation of the Insurance Committee of the Association, we arranged for a meeting with them of officials of Saint Paul Fire and Marine Insurance Company of Saint Paul, Minnesota, to discuss their proposal for

professional liability insurance for members of the South Carolina Medical Association. A conference of officials of the company and the Insurance Committee were held in the headquarters of the Association in Florence and the matter was left with the Committee for further study and recommendation. The Saint Paul people proposed a cooperative arrangement whereby, members of the Association and the Insurance Company working together might more successfully meet the threat of increasing mal-practice insurance claims and suits. No group policy or reduced premium is involved at first, but we were assured that as the experience in the State warranted, a financial saving could be effected. The company has similar arrangements with other State Associations and all the reports we have received concerning them have been satisfactory.

In November, 1957, we attended the Conference of Journal Editors and Business Managers arranged by the State Journal Advertising Bureau in Chicago, and following this meeting also the Conference on School Health at Highland Park, Illinois.

While the activities and interests of the Association during the past year have not included anything of an outstanding or exciting nature, such as the legislative fights of a couple of years ago, its affairs have run smoothly and, so far as we know, in a highly satisfactory condition. The members and the staff took the financial changes in stride, and generally speaking, we think the business of your organization is in an unusually sound and healthy condition.

Last fall, we made a special effort to arrange for more visits to County Medical Societies to discuss Association business. Letters to the County Secretaries indicating our wishes and availability along this line brought a number of courteous responses and invitations, all of which were accepted with the exception of one or two which were prevented by conflicts of other engagements. In every instance, we were cordially received and left the meeting feeling that the visit had helped to promote and cement somewhat the relationship of the State Organization and the component society. We expect to continue a similar program of activities next fall.

Once again we wish to express our thanks to Dr. Lesesne Smith, President of the Association, Dr. Cain, the Chairman and other members of Council, Dr. Wilson, the Secretary, and Dr. Stokes, the Treasurer of the Association, for their unfailing attitudes of cooperation and understanding in all of our efforts to carry on the administrative and legal work of the Association.

Respectfully submitted,
M. L. Meadors

PRESIDENT SMITH: Thank you, Mr. Meadors, for this very comprehensive report. It will be referred to the Reference Committee on Miscellaneous business.

The next report is from our Secretary, Dr. Robert Wilson.

REPORT OF THE SECRETARY

The office of the Secretary of the South Carolina Medical Association is to some extent limited in scope, duties, and responsibilities, but it is an interesting one. Most of the details of membership, the secretarial details connected with the annual meeting, the House of Delegates, and membership on the Committees of the House, and much of the correspondence with the American Medical Association is carried out by the Executive Secretary, Mr. M. L. Meadors. To him I owe a debt of gratitude for a job well done, and his efficiency in this capacity takes a great load off the work of the Secretary.

As Secretary of the Council I have attended all meetings of this group and have carried out its directives.

The success of the work of the Council is very largely due to the effort and work of its Chairman, Dr. J. P. Cain of Mullins, and to him the Association owes its sincere thanks.

Much of the work of the Secretary is in correspondence and answering inquiries regarding placement of physicians and questions of membership. The Secretary keeps a list of those communities in the State where physicians are needed, but he is completely dependent on the membership of the Association to apprise him of the opportunity of practice in various localities, and any information in this regard would be extremely useful. Certification of membership in the Association is another duty of the Secretary, and it is particularly important to physicians applying for licensure in various states other than South Carolina.

As Secretary I have no particular suggestions to make this year and I would like to thank the House of Delegates for the honor and privilege of having served in this capacity.

Respectfully submitted,

Robert Wilson, Secretary

PRESIDENT SMITH: Thank you, Dr. Wilson. The report will be referred to the Reference Committee on Council and Officers.

I would like to ask Dr. Workman to see if he can locate the President of the Woman's Auxiliary. The next report is from Dr. Howard Stokes, our Treasurer.

South Carolina Medical Association Report on Audit

January 1, 1957 to December 31, 1957

Revenue:

A. M. A. Dues	\$30,598.50	
Membership Dues	21,328.00	
Subscription Dues	3,830.05	
Advertising	27,662.49	
Interest Earned	729.12	
Directory of Members	7.00	
Miscellaneous	1,528.50	
Gross Revenue		\$85,683.66

Less-Expenses:

A. M. A. Conventions	685.74	
Dues and Subscriptions	178.88	
News Letter	628.41	
Heat, Lights, Water and Fuel	42.32	
Insurance	50.02	
Office Supplies	2,090.66	
Journal Printing and Expenses	17,319.74	
Rent	1,260.00	

Salaries:

Editor	\$1,800.00	
Director of Public Relations	8,200.00	
Secretary and Others	8,211.50	18,211.50
Postage	211.04	
Telephone and Telegraph	1,645.12	
Travel Expenses	1,683.41	
President's Office Expense	1,302.75	
Audit and Legal	769.00	
Public Relations Expense	261.57	

Refunds and Transfers	460.00	
Woman's Auxillary Bulletin	1,417.35	
Naturopathy	1,000.00	
A. M. E. F. Educational Fund	1,000.00	
Taxes	282.63	
Miscellaneous Expenses	1,203.49	
Maternal Welfare Committee	200.00	
Historical Committee	200.00	
A. M. A. Dues	30,400.00	
Total Expenses		82,503.63
Excess of Revenue Over Expenses		\$ 3,180.03

South Carolina Medical Association Florence, South Carolina Statement of Receipts and Disbursements January 1, 1957 to December 31, 1957

Balance on Hand, January 1, 1957:

Guaranty Bank and Trust Company	\$ 1,350.64	
Bank of Florence	500.00	\$1,850.64

Receipts:

Statement of Revenue and Expenses	85,683.66	
Withholding Taxes	1,908.49	
Collections—Accounts Receivable	337.50	
Permanent Home Building Fund	510.00	88,439.65
Total		90,290.29

Less-Disbursements:

Expenses, Per Statement	82,503.63	
Withholding Taxes	1,858.43	
Accounts Receivable	505.00	
Furniture and Fixtures	355.48	
Taxes	81.62	
Interest Earned on Investments	641.62	
Total		85,945.78
Balance, December 31, 1957		\$ 4,344.51

Represented by:

Guaranty Bank and Trust Company	\$ 1,350.64	
Bank of Florence		1,010.00
Balance, December 31, 1957		\$ 4,344.51

South Carolina Medical Association Florence, South Carolina Reconciliation of Bank Account December 31, 1957

Balance on Hand, January 1, 1957:

Guaranty Bank and Trust Company	\$ 1,350.64	
Deposits	85,338.98	
		86,689.62
Disbursements		83,355.11
Balance per Books, December 31, 1957		\$ 3,334.51

Balance per Bank Statement, December 31, 1957	\$ 5,401.88
Less-Outstanding Checks:	
Checks #	
1263 (1951)	\$ 10.00
405 (1953)	49.52
1457 (1955)	17.00
2315	5.00
2316	5.00
2334	45.00
2352	57.50
2795	20.00
2796	5.00
2838	115.00
2839	25.00
2878	25.00
2902	3.00
2917	212.50
2918	20.80
2919	24.38
2920	262.48
2921	123.28
2922	100.00
2923	146.62
2924	70.01
2925	43.85
2926	87.75
2927	283.71
2928	9.77
2929	200.00
2930	100.00
	<u>2,067.37</u>
Balance per Books, December 31, 1957	\$3,334.51

South Carolina Medical Association
Florence, South Carolina
Schedule of Salaries Paid
January 1, 1957 to December 31, 1957

Dr. J. I. Waring	\$ 1,800.00
M. L. Meadors	8,200.00
Mrs. Claude G. Watson	975.00
Mrs. Bertha P. Moote	
Regular Pay	\$ 4,030.00
Overtime Pay	14.00
	<u>4,044.00</u>
Jamea W. Nonely	828.75
Virginia W. Mitchell	900.00
Margaret C. White	323.75
Francis B. Taylor	900.00
Sadie Myers	240.00
Total	<u>\$18,211.50</u>

South Carolina Medical Association
Florence, South Carolina
Balance Sheet
December 31, 1957

Assets

Current Assets:	
Petty Cash	\$ 205.00
Bank	4,344.51
Accounts Receivable	1,374.75
Total Current Assets	\$ 5,924.26
Investments:	
U. S. Government Bonds	10,000.00
Peoples Federal Savings and Loan	10,842.89
Security Building and Loan	5,918.78
S. C. National Bank	2,817.40
	<u>29,579.07</u>
Fixed Assets:	
Furniture and Fixtures	5,911.44
Other Assets:	
Deposits Receivable	3.00
Total Assets	<u>\$41,417.77</u>

Liabilities

Current Liabilities:	
Withholding Taxes	\$ 138.02
Permanent Home Building Fund	1,010.00
Surplus	
Balance, January 1, 1957	\$37,089.72
Excess of Revenue Over Expenses	3,180.03
Total Surplus	<u>40,269.75</u>
Total Liabilities and Surplus	<u>\$41,417.77</u>

We have examined the treasurer's records of the South Carolina Medical Association for the year ending December 31, 1957.

We certify that in our opinion the above Balance Sheet and accompanying Statement of Revenue and Expenses set forth the financial position of the South Carolina Medical Association as at December 31, 1957, and the results of its operations for the period ended on that date.

Respectfully Submitted,
Jaillette & Brunson
Public Accountants

PRESIDENT SMITH: Thank you Dr. Stokes. I understand that the Treasurer's report will be published in detail either in the June or July issue of the Journal.

The next report will be from the Editor of the Journal, Dr. Joe Waring.

REPORT OF THE EDITOR

There has been no great change in *The Journal* during the past year. An effort has been made to improve its appearance and to produce it on a reasonably accurate schedule. A better patronage by advertisers has been a gratifying development and salvation for a formerly tottering budget.

During the year a questionnaire concerning *Journal* matters was published and our members were asked to fill it in, not to satisfy our idle curiosity, but to offer their constructive comment on a subject about which those chiefly concerned seem to get the least report. The response to this request was amazing; in fact, it probably set some low record for all time. From our 1200 members we received 6 replies. Not satisfied that these few voices represented the basic thinking of our Association, we set about using underhand means of getting a larger response. We practically bludgeoned people at meetings, we enlisted the aid of the Woman's auxiliary and of the county secretaries, and by such strenuous effort we managed to amass 140 questionnaires with more or less complete replies on them.

The information was of great interest as an approximate indication of opinion. While obviously there was a difference varying with the interests of the man behind the reply, there was some uniformity in preferences which was informative. There was also the inevitable sharp suggestion that *The Journal* be abolished, and the smug statement that the writer never reads *The Journal*, as well as the thought that advertisements be deleted or reduced, a thought revealing little knowledge of *Journal* economics.

Concerning scientific papers there was an overwhelming request for more—a laudable thought, and no editor could be more of an *Oliver Twist* in asking for more than is yours. Papers come the hard way to us. We cannot expect all the products of our state to reach us, but we could have more than we get. Even so, the editorial conscience must sometimes reject papers when they do not meet reasonable standards of value.

There was some pleasant surprise in finding that the editorial features were well received. Special

articles were also acceptable, and news and personals seemed to be in favor. Most of the replies indicated that *The Journal* was read every month, although it was apt to be seen after other journals had been read.

Book reviews seemed to be in least favor, as half of the replies suggested abolition of this feature. Obtaining reviews involves great effort and much wheedling, but reviews seem to serve some purpose and happily to fill some space left gaping by a deficiency of other brief material. Perhaps they are not worth while, but 50 per cent of interest is good interest.

A number of good suggestions were made. Some are beyond the range of a Journal with a limited budget and a part-time editor, but it may be possible to carry others into effect. Your editor would be happy to have more suggestions, with perhaps some indication of means for implementing them, not only from the faithful 150 members who gave time and effort to replying to our request, but also from the great bulk of the thousand and fifty who remained sturdily and, perhaps, tactfully, inarticulate.

J. I. Waring, M. D.

PRESIDENT SMITH: Thank you, Dr. Waring. You have our sympathy. Your report will be referred to the Reference Committee on Council and other Officers.

Gentlemen, at this time it is our pleasure to have with us as our guests the President of the Woman's Auxiliary. She is from our county and we are delighted to have with us Mrs. Belton Workman.

MRS. WORKMAN: Thank you, Dr. Smith. As president of the Auxiliary I would like to thank you for your cooperation with us in our work. We have a membership of 811, and we have given between twelve and fifteen hundred dollars from our organization. We are sorry that our delegate is not here but we are happy that our State incoming President is here, and I would like to present to you Mrs. George Orvin of Charleston.

MRS. ORVIN: I thank you gentlemen very much. It is a pleasure to be here with you. All I have to ask for is your continued support throughout the next year. I know we will receive that, and we are here to help you in any way we can or do anything for you men that it is possible for us to do.

PRESIDENT SMITH: I thank you very much, Mrs. Workman and Mrs. Orvin for being here with us. Our next report, which is the most important, is from the Chairman of the Council, Dr. Joe Cain.

From a legislative standpoint, both the optometry bill and the naturopathy bill were resurrected during the present session, however we are happy to say that with the full cooperation of our legislative committee and local societies, we were able to keep both bills in the committee. Also, as we brought out in detail in Mr. Meadors report, there has been police action by the State Law Enforcement Division against the naturopaths in the state, who are still practicing. This has resulted in a conviction and fine of one of the naturopaths, and the Law Enforcement Division is now accumulating evidence against the others.

It should be borne in mind that a bill was introduced in the General Assembly this year in an attempt to restore the practice of naturopathy in South Carolina. This bill was introduced by Representative Mitchell from Oconee County, who himself is a naturopath and who managed to have himself elected a member of the delegation from Oconee County to serve an interim appointment. This served to point out the possibility of this type of legislation hounding us for years to come and should stimulate us in our individual counties to take an interest in these elections and see that no naturopath is elected to the House of Representatives. This is a real threat.



MRS. GEORGE ORVIN
President, Woman's Auxiliary, 1958-1959

Most of these fellows are real personable individuals and have good voter appeal, as a matter of fact three are now running for election this summer, Mr. Mitchell is running for re-election in Oconee County, Mr. Blondo in Lexington County and Mr. Beck in Charleston County. I hope that this warning will be all that is necessary to be said in this regard.

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I would like to commend the work done by Dr. Charlie Wyatt, Vice-Chairman of council and Chairman of the Civil Defense Committee appointed by council. Dr. Wyatt has been working very hard on this job and was very helpful in securing remedial legislation necessary to overcome such problems which were holding back Civil Defense in South Carolina. We hope that each one of you will cooperate to the fullest when asked to do so by the Medical Chairman in your individual counties.

DR. CAIN: At this time I want to take time to go into these recommendations, to tell you what complaints were filed and what Council tried to do about that. In the first place Council wanted to know whether or not the State Association was sufficiently interested in Blue Shield to back it, whether they wanted Blue Shield to grow or die, which they are on the vine, and which it apparently had all the aspects of doing last year. The almost unanimous opinion was that there was a place for Blue Shield in South Carolina, and that some sort of a plan could and should be worked out. That was the first question that was asked. If the doctors over the State did not want Blue Shield, then the rest of the discussion was

superfluous. However, they seemed to want Blue Shield, and we set about to find out what the complaints were and what could be done about it. Opinions were asked, whether or not the four thousand dollar limit was a fair limit for the basic Blue Shield contract, and whether or not there might be a preferred contract in case a family should have an income higher, say of six thousand dollars. It was the consensus of the majority of the county societies, that there be two contracts, one the basic standard contract, with service benefits for families with incomes of four thousand dollars or less, and a preferred contract for families with incomes of six thousand dollars or less or individuals with thirty-six hundred dollars or less.

Number 3, the fee schedule. Without going into the amounts of the fee schedule, the relative value schedule was discussed, and it was decided that even though the relative value schedule was hard to understand at first, it had sound actuarial advantages and had the advantage of being able to be changed, and all in all, that it was a pretty good thing to have. Therefore we thought that the relative fee schedule should be continued. However it was asked that there be certain revisions upward in the present schedule. Several alternatives in the fee schedule were offered; that the relative value be upped so that there would be a minimum of a two point value to each procedure, which means in effect no procedures would be less than \$5.00. The other fees would remain the same. Or an alternative which would raise the surgical and obstetrical fee schedule and add on a rider of medical anaesthesia and other benefits which would require a premium increase accordingly. The majority of the visitors felt they would like to have the schedule which had been published, with the upped provisions with a minimum of two point up to \$5.00, and therefore that recommendation was presented by Council.

There was certain definite objection in the agreement between the plans and the position in the physician contract. For instance last year's contract called for 13 months notice from a person dissatisfied with the plan. That 13 months was changed to 40 days on recommendation of Council. There was also a question as to malpractice insurance, which was required in the contract issued last year, and some people objected to. That provision has now been removed from the present contract.

Some of the doctors objected to having their patients sign as to whether they got four thousand dollars a year or more or less; others thought it was a pretty good thing, that it gave an excuse to inquire into the financial condition of the patient, and was less embarrassing to do it that way. There seemed to be a definite division of opinion on that and so the recommendation was that it be made as an alternative requirement; you can either do it or else not do it, either you want to do.

The clause in the manual having to do with free choice of physician was recommended to be changed so that free choice of physician could be maintained, and that the service of non-participating physicians would be paid for at the same fee as those performed by participating physicians; the point of exception being that the Blue Shield plan paid a participating physician direct, but the non-participating physician would have to collect his bill from the patient to whom the Blue Shield paid the fee.

One of the biggest problems that we had to face, and one of the many objections to the Blue Shield plan in one form or another, and it took a variety of forms, was the difficulty that physicians have in their relationship with patients who have Blue Shield contracts. There seemed to be a great deal of misunder-

standing on the part of the patient and the doctor as to just which services were paid in full benefits, and which were indemnity benefits, that is, where they were able to collect fees from the patients. Some doctors felt that all benefits under the Blue Shield were service benefits and they could not collect anything further from the patients under any circumstances, and therefore they felt they would be grossly underpaid. Some of them felt the contracts were misrepresented to the patients, so even if it were not true all benefits were service benefits, that at least that was what the patients were told, and it was poor public relations for them to argue with the patients, and rather than do so they would let the fee go and of course along with it the attitude of "to hell with the Blue Shield." So we felt that one thing to be done to help clarify the situation, would be to in some manner let the patients who own the Blue Shield contracts understand in no uncertain terms just what their coverage was, and also to have it printed so that the doctors could read it also, and on the basis of this printed evidence arrive at some satisfactory conclusion with their patients regarding fees. So we took all the points which were included within the contract, which were already there, although they were sort of hard to weed out, and we recommended that these be incorporated in a list which would be printed on the front of the Blue Shield contract, and also on the back of the identification card so there would be no excuse on the part of the patient, no matter what they may have understood when they bought their contracts; once they got it they knew just what the requirements were. And just so we might all understand this, I want to read the list which is printed on the front of the Blue Shield contract and which will be printed on the identification card in the future. (List read.)

This particular one here (referring to list), if you have a patient in the hospital and he or she goes into a real high priced private room, which costs say \$15.00 a day, and the Blue Cross pays \$7.00 toward that, they gladly pay the hospital \$8.00 additional for the days they stay and have a private room, and yet when you send them a bill they say their income is under four thousand dollars, and that they are entitled to service benefits under the Blue Shield. Numbers of doctors feel that this was grossly unfair, that a person was in reality having a luxury at their expense, so that the recommendation was that in any case where private nurses, private rooms or any accommodation higher than that called for by the Blue Cross contract, except where prescribed by the doctor as necessary for the patient's care, the Blue Shield benefit is charged.

So those are the recommendations by Council made to the Blue Shield board, along with two others, one which was that the non-group contract be continued. There was a lot of discussion about that, and as a matter of fact the non-group contract is the one that is giving more complaint than the others, because it has no medical benefit whatever. However, there has to be some way that the individual can be taken care of if he leaves the group; in other words if a person is covered in a certain business and he loses or changes his job and he has no insurance, then he should be able to take a non-group policy if he wants to and for that reason the non-group was continued.

And number 2, in order that all of these questions which we found out only by going back to the counties and talking it over, the reasons for the grievances and also the answers which we hope were satisfactory, that the conditions would not recur, that the Council itself act as a liaison committee and take back information concerning Blue Shield to their individual counties and in turn Blue Shield would supply the

Council with this information and, in the form of monthly and quarterly reports. So these recommendations were made to Blue Shield. It was recognized that these would not please everyone, but it was hoped that the majority of the complaints would be eliminated and prove a basis for workable society, which the society could and would support. They were recommended and accepted *in toto* and are now in effect.

PRESIDENT SMITH: Thank you, Dr. Cain. The first part of this report that pertains to Blue Cross and Blue Shield, will be referred to the Reference Committee on Insurance, Blue Cross and Blue Shield. The last part of your report dealing with legislation will be referred to the Committee on Legislation and Public Affairs.

And the next report will be from the Delegates to the American Medical Association annual meeting. Our Senior Delegate, Dr. William Weston.

REPORT ON ACTIONS OF THE HOUSE
OF DELEGATES
AMERICAN MEDICAL ASSOCIATION
to the
SOUTH CAROLINA MEDICAL ASSOCIATION
106th ANNUAL MEETING

June 3-7, 1957

NEW YORK CITY

Dr. Gunnar Gundersen of La Crosse, Wis., member of the A.M.A. Board of Trustees since 1948 and chairman for the past two years, was unanimously chosen president-elect for the year ahead. Dr. Gundersen will become president of the American Medical Association at the June, 1958, meeting in San Francisco. The House of Delegates voted the 1957 Distinguished Service Award of the American Medical Association to Dr. Tom Douglas Spies, head of the department of nutrition and metabolism at Northwestern University Medical School, Chicago, and director of the nutrition clinic at Hillman Hospital, Birmingham, Alabama, for his outstanding contributions to the science of human nutrition. For only the third time in A. M. A. history, the House also voted a special citation to a layman for outstanding service in advancing the ideals of medicine and contributing to the public welfare. Recipient of this award was Henry Viscardi, Jr. of West Hempstead, N. Y., founder and president of Abilities, Inc., which employs only severely disabled persons.

The House approved the long-discussed revision of the Principles of Medical Ethics, originally submitted at the 1956 annual meeting in Chicago. In an excerpt from the Preamble, the final version now reads as follows: "They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public."

The House adopted the "Suggested Guides to Relationships Between State and County Medical Societies and the United Mine Workers of America Welfare and Retirement Fund." In approving the guides, the House also recommended that the Board of Trustees study the feasibility and possibility of setting up similar guides for relations with other third-party groups such as management and labor union plans.

The action concerning the UMWA Fund has received much publicity in recent weeks, but I feel that one statement from the "General Guides" should be stressed. That is, "*Free choice of physician and hospital by the patient should be preserved.*"

New Statement on Medical Schools

To replace the "Essentials of an Acceptable Medical School", initially approved by the House of Delegates in 1910 and most recently revised in 1951, the House adopted a new statement entitled "Functions and Structure of a Modern Medical School." Presentation of the document followed a year of careful study by the Council on Medical Education and Hospitals in collaboration with the Association of American Medical Colleges.

The statement is intended to provide flexible guides which will assist in "attaining medical education of ever higher standards" and "serve as general but not specific criteria in the medical school accreditation program." The document encourages soundly conceived experimentation in medical education, and it discourages excessive concern with standardization.

Social Security for Doctors

The delegates reaffirmed their opposition to compulsory coverage of physicians under the Old Age and Survivors Insurance provisions of the Social Security Act.

Miscellaneous Actions

The House also congratulated the Board and the Committee on Poliomyelitis for their prompt action in stimulating national interest in the polio immunization program;

Recommended further study and a progressive program of action, probably including legislative changes, to solve the problem of narcotic addiction;

Urged a more careful screening of television and radio patent medicine advertisements;

Directed the Board of Trustees to investigate the indiscriminate use of stimulants such as amphetamine, particularly in relation to athletic programs;

Opposed the establishment of any further veterans' facilities for the care of non-service-connected illnesses of veterans;

Condemned the compulsory assessment of medical men and staff members by hospitals in fund-raising campaigns.

The Goldberger Award in nutrition research was presented to Dr. Paul Gvory of Philadelphia. An A. M. A. Citation was awarded to the Parke-Davis & Company for its continuing series of institutional advertisements telling the story of medicine and medical progress. Dr. H. G. Weiskotten, who retired after many years as chairman of the Council on Medical Education and Hospitals, received two bound volumes of letters of appreciation and also an ovation from the House of Delegates.

At the Wednesday session of the House the Illinois State Medical Society made a record state society contribution to the American Medical Education Foundation by turning over \$170,450 to Dr. Louis H. Bauer of New York, foundation president.

CLINICAL MEETING

December 3-6, 1957—Philadelphia, Pa.

The meeting of the House of Delegates in Philadelphia was called to order on December 3, 1957, with an attendance of 192 delegates out of a possible 198.

Dr. Cecil W. Clark of Cameron, La., was named the 1957 General Practitioner of the Year after his selection by a special committee of the Board of Trustees for outstanding community service.

Dr. David B. Allman, President, in his address called for "more freedom, not less, in America and in the medical profession."

In the Directory-Biographical Department particular attention was called to the fact that the 20th edition

of the Directory will be available in September, 1958; that machine methods of printing the Directory are being adopted as rapidly as possible, and that the Directory is self-supporting by reason of subscription fees to the semi-monthly Directory Report Service. The Committee on Legislation emphasized the urgent need for all representatives of American medicine to be properly informed on pertinent legislative matters and the need for better channels of communication between the Committee on Legislation, the various state and county medical societies, and individual physicians.

The Reference Committee believes that wholehearted effort is being made to present the ideals and policies of the A. M. A. to the general public by means of all acceptable news mediums and that the Department is following an effective program in an effort to control stories, advertising, and misinformation which might mislead the general public in matters of public and personal health. Attention was directed to the National Science Fair as a worthy project which merits continued support from state and county medical societies as a form of public information. Consideration was given to more effective methods of keeping the A. M. A. membership properly informed on all matters of interest to physicians. The Reference Committee pointed out that the responsibility for properly indoctrinating new members belongs at the local rather than at the national level.

A report recommended that for several reasons the Association discontinue the use of fluoroscopes for the fitting of shoes, particularly because technical studies have demonstrated that a high percentage of shoe-fitting fluoroscopes are frequently in poor repair and emit dangerous stray radiation, thereby exposing shoe sales personnel, customers, and bystanders to a hazard which they do not recognize or appreciate and which cannot be controlled effectively.

A complete report on an exhaustive study of the subject of fluoridation of public water supplies was presented by a joint committee of the Council on Foods and Nutrition and the Council on Drugs, in accordance with the action of the House of Delegates at its meeting in Seattle, November 27-30, 1956. The conclusions and recommendations of the joint committee were as follows:

1. Fluoridation of public water supplies so as to provide the approximate equivalent of 1ppm of fluorine in drinking water has been established as a method for reducing dental caries in children up to 10 years of age. In localities with warm climates, or where for other reasons the ingestion of water or other sources of considerable fluoride content is high, a lower concentration of fluoride is advisable. On the basis of the available evidence, it appears that this method decreases the incidence of caries during childhood. The evidence from Colorado Springs indicates as well a reduction in the rate of dental caries up to at least 44 years of age.

2. No evidence has been found since the 1951 statement by the Councils to prove that continuous ingestion of water containing the equivalent of approximately 1ppm of fluorine for long periods by large segments of the population is harmful to the general health. Mottling of the tooth enamel (dental fluorosis) associated with this level of fluoridation is minimal. The importance of this mottling is outweighed by the caries-inhibiting effect of the fluoride.

3. Fluoridation of public water supplies should be regarded as a prophylactic measure for reducing tooth decay at the community level and is applicable where the water supply contains less than equivalent of 1 ppm of fluorine.

The Reference Committee commended the report of Judicial Council to the members of the House for serious study. It called attention to the fact that the 1957 edition of the Principles of Medical Ethics was not intended to and does not abrogate any ethical principle and endorsed the statement that if local societies fail to curtail unethical practices ethics lose their effectiveness. Failure on the part of the component society to demand respect for and adherence to the Principles breeds contempt and disrespect for them.

Special attention was called to the recommendation that the House of Delegates urge every state medical association and county medical society to participate actively in the planning and operation of medical care programs for the indigent.

The Committee to Study the Heller Report transmitted the following recommendations for House action:

The offices of Secretary and Treasurer be combined into one office to be known as Secretary-Treasurer, and that the Secretary-Treasurer be selected by the Board of Trustees from one of its number.

The duties of Secretary-Treasurer be separated from those of General Manager (or Executive Vice President).

The position of Executive Vice President be substituted for that of General Manager, the Executive Vice President to be appointed by the Board of Trustees as the Chief Staff Executive of the Association.

Your delegate wishes to make a recommendation that the Chairman appoint a committee from Council to investigate the feasibility of Social Security and report back to the Council at the meeting in the Fall.

Respectfully submitted,

William Weston, Jr., M. D.

Delegate to the American Medical Association
from the South Carolina Medical Association

PRESIDENT SMITH: Thank you, Dr. Weston.

Dr. George Dean Johnson, will you give us your report?

DR. JOHNSON: There is no additional report, Mr. President.

PRESIDENT SMITH: Thank you sir. This Committee Report will be referred to the Standing Committee on Miscellaneous Affairs.

Gentlemen, our next order of procedure will be the report of the Standing Committees. The first standing committee to report is the Committee of Scientific Programs. First I want to thank Dr. Robert Stanley, the Chairman, Dr. John K. Webb and Dr. Williard C. Hearin, Jr., and I would like to have a report from Dr. Stanley on this committee. (Report read by Dr. Stanley.

REPORT OF THE SCIENTIFIC COMMITTEE OF THE SOUTH CAROLINA MEDICAL ASSOCIATION 1957-1958

We, the undersigned, wish to express our gratitude to Dr. Lesesne Smith and Dr. Robert Wilson who have served as ex officio members of this committee. Also thanks to Dr. J. I. Waring, Mr. M. L. Meadors and to Dr. William Cantey and his committee for 1956 and 1957. We also express thanks to many other people too numerous to mention individually upon whom we have called for advice and information at various times throughout the past year.

On the basis of experience gained this year the committee feels that the practice of having all members from the same locality should be continued for obvious reasons.

This committee feels that the form and content of all future annual scientific programs will necessarily

have to be left to the discretion of whatever committee is responsible. At the same time we urge that the Association seriously consider the offer from the State Heart Association to obtain and underwrite the expenses of a speaker at each annual session. This speaker to be someone prominent in the field of cardiology.

Our secretarial assistants have been called upon for a great deal of work in addition to their usual duties, and we believe that compensation from the State Association is very much in order.

Respectfully submitted,
Robert R. Stanley, M. D., Chairman
J. K. Webb, M. D.
Willard Hearin, M. D.

PRESIDENT SMITH: Thank you Dr. Stanley. Gentlemen I would like to mention to you before we proceed, that many of these committee reports have been published in the April issue of our *Journal* and therefore will not have to be read unless there is some addition that the Chairman wishes to make.

The next committee report is the Committee on Legislation and Public Relations, Dr. O. B. Maver. Do you have any additional report?

DR. O. B. MAYER: I have a report to make but not under that heading. I have a report to make on the Highway Safety Program.

PRESIDENT SMITH: We will get to that. The next Committee report is Committee on Public Health, Dr. Harrison, Chairman.

DR. HARRISON: No report, Mr. President.

PRESIDENT SMITH: The next Committee is the Memorial Committee, which we will hear on Thursday morning.

The next committee to report, if you have any additional report, is the Committee on Maternal Welfare. Dr. Hester, Chairman.

DR. HESTER: No report, Mr. President.

PRESIDENT SMITH: Next committee is Committee on Infant Child Health, Dr. Walter Hart. His Committee report is in the journal.

The next Committee is the Committee on Cancer, Dr. James R. Young, Chairman.

DR. YOUNG: No report.

PRESIDENT SMITH: The next committee report is the Committee on Grievances, Dr. MacDonald, Chairman.

DR. MACDONALD: I have no report other than what I sent to Dr. Cain, Chairman of Council.

PRESIDENT SMITH: Well it is in *The Journal*.

The next committee is the Committee on Historical Medicine. Any report from Dr. Waring?

DR. WARING: No further report.

PRESIDENT SMITH: Next, Committee on Medical and Hospital Insurance Contracts, Dr. Joe Cain, Chairman.

DR. CAIN: I am sorry we didn't print this in *The Journal*. I was waiting to make a real good report. I hoped that I could say that our insurance program had been completed. We are working on one additional district which has not qualified. Whether or not that district will qualify I do not know; however it will have no effect on the others which have qualified and are now in effect.

I would also like to say that the Committee is studying malpractice insurance. We have been approached by one or two companies, who would like to give us coverage, and there has been no investigation into the realm of health coverage. Just what this is going to bring forth I don't know just now.

PRESIDENT SMITH: Thank you Dr. Cain. This report will be referred to the Committee on Insurance, Blue Cross and Blue Shield.

Next, Committee on Rural Health, Dr. Workman or Dr. Marshall present? The report is in *The Journal*, no additions.

Next, Committee on Indigent Care, Dr. John A. Siegling, Chairman.

DR. BEN N. MILLER: Mr. President, Dr. Siegling is away and he asked me that I give the report to the Delegates. The report is in *The Journal*; however there are certain matters in reference to by-laws that carry out the wishes of the Delegates reported on last year, and recommended by the group this year. At the meeting last year it was passed by the House of Delegates that a standing committee be formed and appropriate by-laws be passed, and I might ask if I am in order, that I read now the proposed change in the by-laws.

PRESIDENT SMITH: Yes, sir.

COMMITTEE ON THE CARE OF THE INDIGENT

While no special legislation has engaged the attention of this Committee during the year, the magnitude of the problem of the care of the indigent on a state and national level merits having a Standing Committee, of which the members serve for a sufficient length of time to familiarize themselves with the problems involved.

In 1957 your Committee recommended that "a standing committee on indigent care be appointed to be composed of five representative members of the profession with the ultimate aim that each member serve for a period of five years. It is suggested that an appropriate amendment to the Constitution and By-Laws be prepared to set up such a committee, the initial group to serve on a staggered basis with the ultimate aim above expressed."

The House of Delegates approved the recommendation and voted that such a five man committee be set up as a Special Committee for 1958.

Your Special Committee for 1958, in line with this proposal, proposes that the appropriate committee of the State Association be instructed to initiate action to change the By-laws so as to constitute this committee as a Standing Committee of the Association in accordance with the recommendation accepted by the House of Delegates in 1957.

John A. Siegling, M. D., Chairman
Dr. John Brewer, Kershaw
Dr. B. N. Miller, Columbia
Dr. Norman Eaddy, Sumter
Dr. Stanley Morse, Beaufort

CONSTITUTION AND BY-LAWS OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

Revision published June 1957.

By-Laws

Chapter VIII, Section 3—Committees: Amend Chapter VIII, Section 3 by adding to the list of Standing Committees a ninth to be known as Section 9 "The Committee on Welfare and Rehabilitation"

Section 12 (Page 23) Change to Section 13 and all successive sections of Chapter VIII increase one digit—change Section 12 to read as follows:

Chapter VIII—Standing Committees

Section 12—Committee—Welfare and Rehabilitation: This Committee will consist of five members appointed for a term of five years by the President of the Association. Tenure of the five initially named members will progress from one to five years in the order recorded by the President. Yearly regular vacancies and vacancies occurring by resignation, or otherwise, will be filled by the President. The Chairman of the body will be elected yearly by members of the Committee. The Welfare and Rehabilitation Committee is assigned the responsibility of advisor and liaison to the several agencies in the field of welfare, rehabilitation, and care of the medically indigent. Annual and interim reports will keep the

Association cognizant of the needs and accomplishments in this area of responsibility. Considered and approved.

Charles May
Kirby Shealy
R. W. Hanckel

PRESIDENT SMITH: Thank you, Dr. Miller. This report will be referred to the Committee on Constitution and By-laws.

Any additional report on medical affairs, or the Advisory Committee to the Crippled Children Society? Dr. James Green is Chairman. Any additional report? If not it will be referred to the Committee on Public and Industrial Health.

Any report on Advisory Council to the Woman's Auxiliary? This is in *The Journal*. If not it will be referred to the Committee on Miscellaneous Business. Next, Committee on Care of Patients, Dr. William Hamilton, Chairman, any additional report? If not, it will be referred to the Committee on Public and Industrial Health.

Next, Committee on Coroners and Medical Examiners, Dr. H. R. Pratt-Thomas, Chairman.

Dr. Pratt-Thomas: No additional report.

PRESIDENT SMITH: Thank you sir, it will be referred to the Committee on Miscellaneous Business.

Next, Committee on School Health, Dr. Moore.

DR. HENRY MOORE: No additional report.

PRESIDENT SMITH: The report will be referred to the Committee on Public and Industrial Health.

Next, Committee on Medical and Educational Foundation, Dr. Howard Stokes, Chairman.

Report by Dr. Stokes published in *Journal*.

PRESIDENT SMITH: Thank you, Dr. Stokes. Your report will be referred to the Committee on Miscellaneous Business.

The next Committee report will be on Civil Defense, Dr. Charles N. Wyatt.

DR. WYATT: Mr. President, Gentlemen of the House of Delegates. As you have been informed this afternoon, we have been struggling for about two years or more making some attempt to get some type of organization within the State for medical care in the event of casualties. During this time we have had quite a bit of obstacles thrown in our path. When the Civil Defense Act was passed by the Legislature in 1950, the Adjutant General was designated as Director of Civil Defense. During the past two years your Committee has made an attempt to organize the State of South Carolina

REPORT OF COMMITTEE ON CIVIL DEFENSE

SOUTH CAROLINA MEDICAL ASSOCIATION

The committee of Civil Defense has, during the year, tried to promote the organization of the medical profession of the state in the medical care of persons in any kind of emergency. We have tried to get material to the Emergency Medical Care Chairman in the various counties that would help them to become more fully acquainted with the problems that may arise in time of an attack or a natural disaster. We have also placed the names of these men on the mailing list of the Civil Defense Review, which is a monthly publication, put out by the AMA, and containing new items, meetings and publications pertaining to Emergency Medical Care.

We were able to send Dr. Sam Fisher, of Greenville, S. C., to attend the annual meeting of the National Defense Council in New York. This meeting is held annually on the Saturday preceding the annual AMA meeting. Mr. M. L. Meadors and I also attended a Southeastern regional meeting of the Civil Defense Council held in Atlanta, Georgia on 5th October 1957. This meeting was attended by representatives from the seven southeastern states and also members

of the Civil Defense Council of AMA. It was a one-day meeting, and was very instructive.

On April (1958) we tried something that we hope may be an annual affair. We had a meeting in Columbia, at which time all the members of the State Association who had been so designated as CD men were invited. Also, we extended to the allied medical professions (Dentist, Pharmacist, Nurses, Vets, and the Woman's Auxiliary of the State Association) an invitation to have representation at the meeting. The attendance was not what we had hoped, but the interest was very keen, and it is hoped that we may be able to have a similar one-day meeting next year.

Perhaps one of the most encouraging events that has happened in the organization of CD in this state was the passage of a bill in the legislature, establishing a separate department of CD within the state government, directly under the supervision and direction of the governor. This bill was sponsored by Senator Alex Woodle of Greenwood County. Senator Woodle is intensely interested in CD, having been present at one of the first nuclear tests in Nevada, (and incidentally was one of our guest speakers at the meeting in Columbia). This bill provides a Director of Civil Defense, who shall be appointed by the Governor, and it also will provide an appropriation for the maintenance and promotion of CD within the state. While this is, as mentioned before, most encouraging, there are certainly matters that we as doctors must follow through. Our organizing for Emergency Medical Care must continue, regardless of the state organization, for, after all, in time of disaster the medical care will be our responsibility.

It is the sincere hope of your Committee that this work be continued, and we earnestly solicit the help of each of you in the promotion of organization of an Emergency Medical Care Unit within your County Society.

Respectfully Submitted,
Charles N. Wyatt

We hope that the incoming Governor can be influenced to give us more aid and that we can at least say something in the selection of the Civil Defense Director. And I would like each and every one of you in the various counties to try to put as much emphasis on this as possible. In case of emergency we are going to be looked to for aid, and if we have not got some organization that can take care of these people, we will be severely criticized. I hope next year we can have an all day meeting and get men of high caliber from the Civil Defense headquarters to attend. We believe if we can get more of the medical profession to attend, it will help us to promote our end of the Civil Defense.

PRESIDENT SMITH: Thank you, Dr. Wyatt. This report will be referred to the Committee on Miscellaneous Business.

The next Committee report is that on Industrial Health, Dr. John Perry. We have a very comprehensive report in *The Journal*, but we will be glad to hear from you.

DR. PERRY: Dr. Smith, the report as submitted is sufficient, but we have two or three additional problems, but they are not in shape to give them as a supplement to the report. So with your permission we will submit them at a later date.

PRESIDENT SMITH: Yes, sir. That will be referred to the Committee on Public and Industrial Health.

Next is the Liaison Committee with allied professions. Dr. John Pratt, do you have anything additional? (no answer).

PRESIDENT SMITH: Gentlemen, there are two committees your President appointed this year, the first one was that Mr. Claude McMillan of the State Highway Department requested that the State Medical Association give advice through a Committee on

Medical Standards for obtaining licenses to drive automobiles, and to have renewed licenses. On this Committee are Dr. Ben Miller, Dr. Tucker Weston, William Morehouse, Dr. Shepherd Dunn, Dr. Bennie Mayer, who I think will make the report.

DR. MAYER: Dr. Smith, I wish now to read the written report that I have, but will ask the indulgence of the President to make a few remarks. He appointed me to represent the South Carolina Medical Association at the Highway Safety meeting, which was held in January. At this time I was appointed by this committee as a member of the executive committee. This executive committee was empowered to arrange for a safety meeting in September of 1957. At this meeting there was some 400 leaders of various organizations throughout the State. These men made certain recommendations, and two recommendations, that have a medical bearing, that I would like to bring to your attention. The first one that came out was a law to permit re-examination of drivers. As you may know, the person who gets his original driver's license is given a blank to fill out and has an examination of his eyes. If there is nothing that the highway patrolman feels is wrong, the person is given a license and unless he violates the law and unless he fails to request a renewal of this permit, he may continue to drive regardless of what disability may develop. So it was for this reason we recommended a re-examination of drivers. As you know, the Legislature failed to enact the law.

The other was that the minimum age limit be raised from fourteen to sixteen. Again that failed to materialize.

When it became apparent that there might be some possibility of having a re-examination for drivers, it occurred to me that there had to be some minimum standard of physical and mental requirements, yet there was none. I was able to get passed a resolution requesting the State Highway officials, Mr. McMillan, to request the South Carolina Medical Association to set up a committee, which the President has told you about. This is a very important committee. It has a function to perform that is almost impossible.

Who knows what the minimum standard is that would permit a man to drive an automobile. Now can these re-examinations be done, if they are done? There are over a million drivers licenses in South Carolina today. If these examinations are standard, as they are in some states, say at an interval of four years, if he is re-examined, what are you going to do? Who would make the examinations? Who is going to pay for the examination? If he has no money, what happens to him then. Would he not be able to drive a car if he has no money? So there are many problems that come forth.

It is true that only a few accidents are directly due to some physical handicap, but it is our belief that if some legislative activity or interest develops for safety, then other measures would be enacted.

I want to call your attention to the death rate from automobiles. In 1956, and I used that figure because we have comparable vital statistics for that year, there were 740 deaths on the highway. There were a total of 18,238 deaths in South Carolina that year. The first killer was heart disease. The second killer, cerebral diseases, and fourth, death on the highway. In other words one death out of every 24 was caused by some accident on the highway. To put it another way, say a town the size of Fairfax or Inman, every two years would have its entire population wiped out by highway deaths.

Knowing your interest in this matter I wanted to bring it to your attention and urge you when you go home to contact your legislative delegation, your Senator, and ask them to vote for safety measures. And to back you up in this I have prepared a resolution I would like to propose. "Be it resolved that the South Carolina Medical Association go on record endorsing the State Highway's Safety Campaign and further lend our support to such legislative acts as will tend to curb the high and dreadful mortality and accident rate on our highways".

PRESIDENT SMITH: Thank you, Dr. Mayer. Your report and resolution will be referred to the Committee on Miscellaneous Business.

(MINUTES TO BE CONTINUED IN NEXT ISSUE)



WOMAN'S AUXILIARY

SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. George Orvin, Charleston, S. C.

Corresponding Secretary: Mrs. John Cuttino, Charleston, S. C.

PRESIDENT'S REPORT 1957-58

The office of President of the State Auxiliary is a most interesting and challenging experience. I am grateful that you have given me the opportunity to serve you and I trust my efforts this past year have helped in a small measure to strengthen our bonds and further the potential of our organization. I am confident that we could not have attained the growth and position we hold today without the splendid cooperation of our past presidents, councilors, chairmen, county presidents and the membership of their auxiliaries. The planning and direction of the committees such as Legislation, Mental Health, Public Relations, etc. need the guidance of chairmen who have attributes and the knowledge of the subjects to inspire the auxiliary. I am interested in the entire program, but I cannot claim to be a specialist or an authority on all facets of our work. Therefore, I wish to commend the excellent chairmen who have activated our program this year. They deserve your enthusiastic support in order to serve the auxiliary and the community effectively.

Now for a brief summary of our 1957-58 auxiliary year.

National American Medical Education Foundation contributions:

Anderson	\$ 20.00
Barnwell	20.00
Charleston	175.00
Columbia	122.00
Greenville	100.00
Greenwood-Abbeville	5.00
Newberry	110.00
Oconee	10.00
Pee Dee	54.00
Pickens	35.00

Spartanburg	550.00
York	20.00

I. TODAY'S HEALTH

The total number of subscriptions received as of April 15, 1958 was 525. This is 60% of our quota.

Newberry County has made our auxiliary proud to have them again in the More Exclusive Club with 417% of their contest quota. In the Exclusive Club the following auxiliaries were honored in Tips and Topics:

- Barnwell County — 125% of their quota
- Berkeley County — 121% of their quota
- Anderson County — 111% of their quota

(Only 6 of the 16 Today's Health chairmen reported.)

II. State . . .

A. The State President has kept in contact with the state Medical Association president and the Advisory Committee. Mimeograph copies of a request from Dr. Cain, Council Chairman, was mailed to all members of the auxiliary Executive Board, also, material was mailed to all members of the Executive Board concerning the State Essay Contest. This contest was sponsored by the Association of American Physicians and Surgeons, Inc. Ten county auxiliaries participating, and as a result the state winners were Shirley Bunch of Shulerville, first; Delores Griffin of Ware Shoals, second; Ann Robinson, Ware Shoals, third. Dr. Thomas Parker, S. C. Chairman AAPS Essay Contest, has written that Delores Griffin's essay won eighth prize in the national AAPS Essay Contest.

B. State Auxiliary Activities

From the eleven county program chairmen, the state program chairman compiled this data.

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1. County Auxiliaries hold from 4 to 9 meetings per year.

2. Activities included projects for mental health, mentally retarded children, civil defense, raising money for the A.M.E.F., assisting with School Safety programs, nurse recruitment, Christmas parties, luncheons, Doctors Day, making gowns for patients at the state Mental Hospital.

3. Programs included such subjects as Civil Defense, A.M.E.F., Safety, Mental Health, Nurse Recruitment, Local Problems, Antique Furniture, History of Nursing, Social Welfare, and the Essay Contest.

4. Most counties do not have an orientation program.

5. The types of programs which brings out the largest attendance are cultural, fashion shows, and luncheons.

6. Every Auxiliary uses guest speakers and these include such persons as doctors, social workers, policemen, nurses and ministers.

7. Films on Civil Defense, Antiques, Mental Health, Cancer and Safety were used and these were obtained from the Medical College, the A.M.A., State Board of Health and from the speakers themselves.

8. No auxiliary reported a program on the Auxiliary Pamphlet and Resolutions.

2. PUBLIC RELATIONS

Most auxiliaries appeared to be more interested in the phase of health education. The auxiliaries worked in close cooperation with the schools on all the various levels, forums, P.T.A., clinics, Future Nurses Clubs. Individual participation of students was encouraged by essay contests. One auxiliary gave prizes of money. Another service the auxiliaries rendered was aiding the health departments in their community health education programs. They served at coffees, arranged flowers for health groups, transported children to health camps, and participated in health fund drives.

In regard to community service and philanthropic work, individual participation is exceedingly extensive. Some agencies which benefited by the auxiliaries and their members were Cancer, Heart, Polio, Crippled Children, United Fund, YMCA, Boy and Girl Scout, Defense Organizations and many others.

In the promotion of the public relations program, some auxiliaries used material from the State Health Department, University of South Carolina Library, National Auxiliary Headquarters and many other sources.

A copy of the Forand Bill and "Reasons Why The Forand Bill Should Not Be Passed," and a copy of "Know Your Members of Congress" was requested by the State Legislation Chairman. The State President has had copies of the latest information sent from our national office on the Forand Bill. These copies will be given out at the convention for your information.

We have a Student Loan Fund available to medi-

cal students and student nurses who meet the necessary requirements.

Our state membership is 811 including 4 members at large, and 74 associate members.

You will note that Ridge and Laurens Auxiliaries were organized last year, but decided to become inactive before the year 1957-58. We need them in our auxiliary and we issue them a cordial invitation to join us next year.

Our Historian reports that all reports given to her by her predecessor have been filed. The County Historians reports along with the President's report will be filed within the next two weeks.

A copy of our State Recruitment program is attached. We consider this the most outstanding state project. We hope to have attractive brochures made concerning this project and pass them out at the national convention.

A detailed report was made of the Doctor Day activities of the some eleven or twelve auxiliaries.

Your president would like to express her appreciation to Mrs. Gordon Able, our immediate past state president, for her guidance, patience and encouragement. She truly deserves an "Oscar" for her outstanding leadership and for her willingness to help others.

We are all looking forward to having Mrs. George Orvin to head our State Organization next year. We know that much will be accomplished under her efficient leadership.

As a token of appreciation your president has made a contribution to A.M.E.F. in appreciation of your cooperation and loyalty.

The mistakes I have made are of the head and not of the heart.

Respectfully submitted,
Mrs. B. J. Workman, President

BOOK REVIEWS

DISEASES OF THE THYROID AND PARATHYROID GLANDS by Bernard J. Ficarra. Intercontinental Medical Book Corporation. New York, 1958. Price \$8.50.

This book by Bernard J. Ficarra is a rather concise (254 pages) but clear and well documented work (750 references) on the thyroid and parathyroid glands.

The book begins with a very brief anatomic review of the thyroid gland and a short review regarding the newer concepts in the physiology of the gland. This reviewer would have liked to have seen a more detailed description of the newer concepts of the thyroid physiology.

The bulk of Dr. Ficarra's book is taken up with the clinical picture of hyperthyroidism, its differential diagnosis and its treatment. There is a very excellent chapter on the treatment of hyperthyroidism in which

the author stresses, once again, the inadequacy of the anti-thyroid drugs as the sole treatment of hyperthyroidism. There is a well organized chapter on thyroiditis with some discussion of the use of steroids in the treatment of non-suppurative thyroiditis. The author also deals with hyperthyroidism in children and pregnant females.

Surgery of the thyroid gland is very adequately covered along with the postoperative complications and a separate chapter is devoted to thyroid crisis.

There is one chapter devoted to thyroid cancer. This subject obviously can only be superficially covered in so short a space. The author does, however, touch on the interesting problem of the pros and cons of surgery of the non-toxic nodular goiter. This reviewer has the impression that the author feels there is a real incidence of malignancy in the nodular non-toxic goiter, particularly in the true adenomas, which justifies surgical intervention.

Finally there is a chapter on hyperparathyroidism which is primarily a brief review of the literature.

There are numerous illustrations throughout the book with several in color.

This reviewer must conclude that Dr. Ficarra's book is a most worthwhile review of the literature presented in a lucid and very readable manner and that it would be a worthwhile addition to anyone's library.

Henry Donato, M. D.

CARDIOVASCULAR DISEASES by David Scherf and Linn J. Boyd. Third edition, Grune & Stratton, New York and London, 1958. Price \$17.75.

During the ten years since its introduction, this book has enjoyed widespread acceptance in half a dozen languages. Its authors, Scherf and Boyd, are Clinical Professor and Professor of Medicine, respectively, at the New York Medical College, and their new English edition contains some 800 well written pages, about nine-tenths of which are devoted to cardiology, the remainder to a brief resumé of peripheral vascular disease. Electrocardiography receives only incidental mention, it being left to the authors' smaller companion volume "Clinical Electrocardiography".

One might characterize this book as a conspicuously "clinical" treatise of the subject. The simple bedside methods of diagnosis of heart disease are emphasized throughout. Of such stuff, surely, the impressive and astute clinician is made. And in a day when cardiac evaluation leans heavily upon more and more highly specialized diagnostic techniques, when catheterization teams and cardiac surgical teams reign supreme, such a review of basic clinical methods is refreshing. Although many of the major advances in cardiac diagnosis and treatment during the last generation are attributable in large part to advances

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in instrumentation, it perhaps needs to be pointed out occasionally that, as the authors assert, "The team's combined viewpoint, if determined solely by seemingly objective data, may be inferior to that of a single observer who knows the patient, the actual symptoms and signs, rather than mere formulas, tracings, and chemical analyses".

In general, discussions of treatment are not slighted and represent middle-of-the-road policy. Considerations of cardiac disease in pregnancy and in surgery will be of interest to physicians in those fields. The subject of hypertension, including the newer antipressor drugs, is well summarized. The frequently recurring term "cardiac neurosis" has perhaps outlived its usefulness, and another, "meteorism", will raise doubts in many readers' minds. References at the end of each chapter are more than ample. Enough physiology and pathology is interwoven with the clinical considerations to illuminate the presentation as well as to serve as a useful review. The excellent organization of the subject matter lends clarity and adds to the value of this book as a source for ready reference in the field of cardiology.

Dale Groom, M. D.

STRABISMUS OPTHALMIC SYMPOSIUM II—

James H. Allen, The C. V. Mosby Company, St. Louis—Price \$16.00.

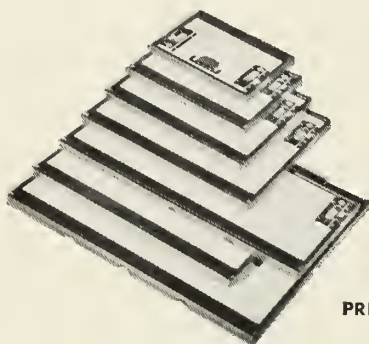
It is refreshing to find that as yet authorities on strabismus are not always in agreement over some very fundamental questions and procedures. This gives one the feeling that his own ideas and conclusions when carefully considered and practically used may not be too bad even if they do not always follow the lead of constituted authority. It can be said without qualification that this book should not only be in the library of every practicing ophthalmologist but should be read by him.

Dr. Walter H. Fink presents interestingly many anatomical facts of great importance to the ophthalmic surgeon. His contribution here is an extended discussion of the same subject presented in the first symposium in 1950, and contains the meat and substance of his unparalleled investigation of the anatomy of the extrinsic ocular muscles.

Dr. Francis Heed Adler in his usual easy and interesting manner discusses voluntary and involuntary mechanisms for eye movements. He relates some of his personal experiments and conclusions and makes some cogent remarks concerning the various types of strabismus from an etiological point of view.

Dr. Kenneth Swan describes the fusional process in clear and concise terms. He makes very practical remarks on the optical, fixational and fusional functions of the ocular motor system and their relationship to sensory components of binocular vision. He describes

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*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

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again the blind spot mechanism, and argues for recession under Tenon's capsule.

Dr. Hermann M. Burian in a straightforward and factual manner approaches the problems and uncertainties in the area of etiology of strabismus. He entertains a hopeful outlook and makes some helpful and indisputable assertions. In discussing normal and abnormal correspondence, stimulating and interesting disagreements among authorities are brought to light; and he is at his best in the all too short chapter on neuromuscular anomalies of the eyes.

Dr. Harold W. Brown makes much over the important cover test. In a clear and sensible manner he discusses congenital structural anomalies of the muscles. In his chapter on surgery of the oblique muscles, he seems very sure of himself, but most of us won't be so sure as to what and when and how surgery is to be done in vertical paresis.

Dr. George P. Guibor has an excellent chapter on some uses of ophthalmic lenses. I found his chapter on clinical application of neurology difficult, as indeed the subject is to many of us. Much in this chapter will tend to increase apprehension as to treatment by those of us who are less experienced. He makes a strong but not too convincing claim for the prolonged use of atropine in treatment.

Dr. Frank Costenbader emphasizes occlusion and orthoptics in treatment of suitable cases. He gives an interesting and practical discussion of the clinical course and management of esotropia, describing well the A and V phenomena.

Dr. Phillip Knapp in discussing divergent deviations argues well for an active divergence with a cerebral center. In commenting on treatment he is very practical, almost too dogmatic, but very convincing. He overemphasizes the importance of orthoptics. He gives on the whole a reasonable and helpful chapter on the surgical treatment of strabismus, although everyone will not agree on certain recommended procedures, and others will argue as to principles involved.

The reprinting from the 1950 Symposium of Dr. Lancaster's two chapters on terminology and over- and underemphasized features of strabismus form two appendices which will be fruitful for all who read. A quotation from Dr. Lancaster is pertinent: "It is a fundamental principle of the medical investigation of a patient that the doctor shall select from the enormous number of possible tests that can be made, those that in his trained and experienced opinion are called for. The patient has a right to expect the doctor to use his trained judgment."

The fifty pages of round table discussion make delightful reading and are alone well worth the volume as an addition to your library.

J. W. Jervy, Jr., M. D.

REVIEW OF PHYSIOLOGICAL CHEMISTRY. Harold A. Harper, Ph. D., Paper. \$4.50. Pp. 376. Lange Medical Publications. Los Altos, California, 1957.

A review of physiological chemistry has been prepared which omits much of the less important (to the physician) details. This text should be of value for preparation for the various state and specialty board examinations and for the practicing physician who wishes to refamiliarise himself with the subject.

W. H. McCord, M. D.

CLINICAL ENZYMOLOGY. Edited by Gustav J. Martin, Sc. D., \$6.00. Pp. 241. Little, Brown and Co., Boston, Mass. 1958.

The use of enzymes in medicine is as old as the practice of medicine. However, the parenteral use of enzymes is relatively new and is the basis of much vigorous discussion. Five contributors have presented here seven aspects of the use of enzymes. Approximately half of the material presented deals with the basic scientific fundamentals of enzyme chemistry and may be of little interest to the practicing physician, but would intrigue the investigator interested in the field.

W. H. McCord, M. D.

DOCTORS IN GRAY—THE CONFEDERATE MEDICAL SERVICE by H. H. Cunningham, Louisiana State Univ. Press, Baton Rouge 1958. Price \$6.00.

This book is a successful effort to supply a story not previously written and to bring to light from extensive source material the facts of the conduct of the Confederate Medical Service. While those who are interested are familiar in a general way with the difficulties which descended on the medical men of the Confederate army and navy, the many details of the struggle which are here displayed have not been available in handy form.

From these pages it may be stated that the Confederate Medical Service forces included able men and that they did an excellent job with what materials and facilities they had available. Their supplies were always inadequate and they faced the handicap of treating patients whose poor nutrition made medical treatment extremely difficult.

For South Carolinians the book holds special interest in the descriptions of the valuable work of Samuel Preston Moore, John Julian Chisolm, and Francis Peyre Porcher, all natives of the state.

J. I. Waring, M. D.

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CARDIAC TRAUMA

WILLIAM H. LEE, JR., M. D. AND J. MANLY STALLWORTH, M. D.
Charleston, S. C.

Developments within the field of cardiac surgery during the past ten years have resulted in a marked increase in the potential salvage rate of patients who sustain injury to the heart. The dire emergency of cardiac wounds and their increasing incidence in this modern world of violent strife and high velocity transportation demand that all surgeons, despite their special interest, develop capability in the emergency management of cardiac trauma. Kissane¹ has stated that 18.5% of 1,000 autopsies on persons with chest contusions demonstrated cardiac injuries; Leinoff² reported 15% gross cardiac injuries in 50 consecutive fatal automobile accidents.

The increasing incidence of civilian heart wounds is reflected by the numbers of patients included in series reported by various authors from 1940-1955 (Figure 1).³

The sources of cardiac trauma are varied and numerous. Common agents are knives, ice picks, glass, bullets, and displaced rib or sternal fragments. There are also crushing chest injuries, as from direct blows to the chest in automobile accidents, falling from great heights, and industrial accidents.

Cardiac injury may be generally classified into two broad types—penetrating and non-penetrating. Penetrating wounds may produce a laceration or a puncture of the myocardium, or both. Non-penetrating wounds produce myocardial contusion, or rupture of one of the walls of the cardiac chamber. Penetrating wounds of the heart, although far less frequent

in civilian life in incidence than non-penetrating ones, generally represent a greater threat of sudden death, and as such, constitute one of the real emergencies of traumatic injuries. The incidence of penetrating cardiac wounds in all cardiac trauma probably varies from 0.1% to 2%, the non-penetrating injuries

Numbers of Heart Wounds Reported (Spencer and Kennedy, 1957)

<u>Author</u>	<u>Year</u>	<u>Number</u>
Bigger	1940	25
Nelson	1943	28
Linder	1944	28
Blau	1945	27
Griswold et al	1947	80
Blalock et al	1949	17
Elkin et al	1951	79
Maynard et al	1952	79
Cooley et al	1955	57
Carr et al	1955	68

of minor or mild degree comprising the majority of instances of injury to the heart.

Non-penetrating injuries may involve any part of the heart, resulting in pneumopericardium, hemopericardium, strangulation of the myocardium by herniation through a torn pericardium, pericardial infections, myocardial lacerations (partial or complete) of any chamber, or valvular rupture. The frequency of involvement of the individual chambers is approximately equal, and multiple lacerations of all chambers are common.⁴ Contusions may undergo pathological changes similar to those of myocardial infarction,

From the Department of Surgery, Medical Center Hospitals, Charleston, South Carolina.

culminating in the development of a ventricular aneurysm, which may rupture months or years later, causing sudden deaths. Valve rupture may produce immediate death or a chronic progressive heart failure over the course of several months or years. The aortic valve is most frequently involved. Transient or chronic persistent cardiac arrhythmias, especially atrio-ventricular block, may follow non-penetrating cardiac trauma.^{5, 6, 7}

A consideration of the diagnostic and therapeutic aspects of cardiac trauma is conveniently approached by a discussion of the resultant syndromes which may be produced by injury to the heart. These syndromes may be generally classified under the following headings:

- (1) Cardiac tamponade — hemopericardium.
- (2) Persistent hemorrhage and shock, with hemothorax or tamponade.
- (3) Severe contusion — with or without myocardial infarction.
- (4) Division of a major coronary artery — with infarction, and with or without tamponade.
- (5) Progressive congestive heart failure, due to rupture of a valve or septum.
- (6) Post-traumatic cardiac aneurysm.
- (7) Intra-cardiac foreign body.
- (8) Conduction disturbances, due to laceration, contusion, or rupture of inter-ventricular septum.
 - a. Ventricular fibrillation.
 - b. Atrio-ventricular or complete heart block.
 - c. Cardiac arrest.

(1) *Cardiac Tamponade*

The diagnosis is classically suggested by the presence of a thoracic injury, faint distant heart sounds at auscultation, a paradoxical pulse, neck vein distention, and a narrowed pulse pressure. Immediate confirmation of the presumptive diagnosis by pericardiocentesis is mandatory. Substantiation by fluoroscopy is not usually indicated, due to the potential danger of the added time needed to perform this examination. Within the past 15 years, the treatment of cardiac tamponade has certainly been the most controversial subject in the consideration of heart injury. Blalock, in 1943,⁸ reported the successful treatment of

acute tamponade by pericardiocentesis alone in a series of patients, and again popularized the non-operative management of this condition. Other investigators soon substantiated these findings, and the previous belief that surgical repair of heart wounds was necessary for recovery (resulting from Rehn's successful cardiorrhaphy previously), was soon abolished. However, particularly within the last three years, the pendulum of opinion has tended to swing back toward operative treatment, making a fairly reasonable compromise in the current writings of most authors. The following generalizations are offered as rational concepts of approaching the question of method of treatment, and decision for operation.

The treatment of shock should be immediately instituted. Blood transfusions, establishment of airway and adequate pulmonary ventilation, with improvement of coronary blood flow by elevating the blood pressure towards normal by the use of vasopressor drugs are the cardinal principles of emergency ancillary treatment of tamponade.

Immediate pericardiocentesis should be performed if acute cardiac tamponade is suspected — both for diagnostic and therapeutic purposes. If tamponade is present, the single aspiration may permanently relieve the tamponade. Helmsworth⁹ reports that over half of the cases of acute cardiac tamponade which were treated by pericardiocentesis, were relieved of all signs and symptoms by a single aspiration. In 14% of his cases, on the other hand, repeated aspiration was inadequate therapy. The remainder of his cases were relieved by two to three aspirations. Other authors, especially Maynard et. al.,¹⁰ have been so unimpressed with the efficacy of pericardiocentesis alone in the treatment of cardiac tamponade in large series of cases, that they recommend thoracotomy in all cases except those who are immediately relieved by the initial aspiration.

Most authorities agree that the presence of repeated episodes of tamponade after the second or third pericardiocentesis, evidence of massive continued blood loss (as manifested by shock and hemorrhage), or large pre-

cordial wounds, are all usual indications for thoracotomy and cardiorrhaphy.

The technique of pericardiocentesis is probably best carried out from the subxiphoid approach, directing a long (spinal) No. 18 or No. 17 gauge needle upward and slightly to the patient's left, to approach the apex of the heart. Bishop¹¹ has presented an ingenious use of the electrocardiogram as a safeguard to avoid ventricular puncture during this maneuver. (Figure 2) The exploring lead of the ECG (chest "V" lead) is connected to the hub of the needle by an alligator clamp couple,

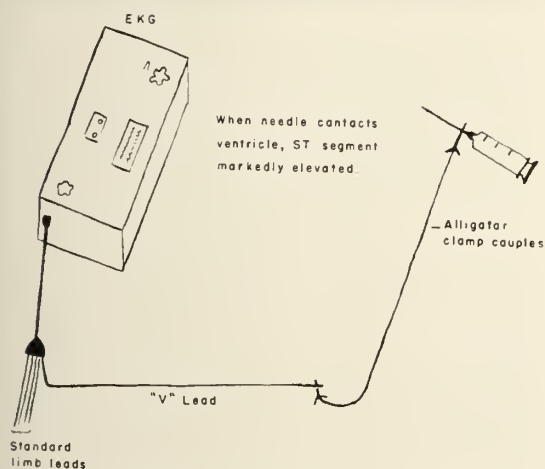


Fig 2 Subxiphoid pericardiocentesis
ECG as safeguard

Bishop, et al.

and contact between the needle and the myocardium is manifested on the ECG by a sudden striking ST segment elevation.

If thoracotomy and eardiorrhaphy are decided upon, the incision of choice is usually a left intercostal incision in keeping with the level of external injury, but almost always between the third and fifth interspaces. If the external wound is on the right, a right intercostal incision may be used. Compressed Ivalon sponge patches may be used to aid in the repair of large rents in the myocardial wall, or septae, but are usually unnecessary.

In general, the heart muscle is sutured in a fashion consistent with the principles of suturing skeletal muscles i. e. large caliber suture material (such as 3-0 or 4-0 silk, atraumatic), placed in fairly large bites of tissue. To secure a quick closure with an effective hemostatic seal, a continuous suture is pre-

ferred by many. This may be buttressed afterwards with interrupted sutures spaced between. Care must be taken to avoid injury to important coronary vessels during the placing of sutures. In closure of the incision there should be adequate drainage of the pericardium, in order to avoid post-operative tamponade due to leakage or exudation.

(2) *Persistent Hemorrhage and Shock* with the hemothorax or tamponade.

As emphasized by Chamberlain,¹² Helmsworth,⁹ and others, massive recurrent hemorrhage or shock with evidence of persistent bleeding, are usual absolute indications for emergency thoracotomy. Closed thoracotomy with sealed drainage should be initiated in the interim awaiting the definitive operation. If, however, after transfusion and thoracentesis, (and alleviation of tamponade, if present) the patient's condition stabilizes and can be controlled, operation may be deferred. Overlong speculation and delay, however, in the presence of uncontrolled bleeding or recurrent hemothorax or hemopericardium, is at this point most frequently the sire of irreversible shock and demise. Many authors point out that very few patients with such severe damage to the heart survive to reach a doctor. The usual occurrence in these cases is death from exsanguination within the space of a very few minutes.

(3) *Severe Contusion*

Myocardial infarction resulting from contusion of the heart has been reported, both in patients with pre-existing coronary artery disease, and, in a few cases, in victims in whom autopsy failed to reveal diseased coronary vessels.⁴ The diagnosis is made by history and ECG (which should be routinely obtained in all cases of chest trauma), and the treatment is essentially that of myocardial infarction from any cause. Minor contusions of the heart require no treatment, other than observation for tamponade due to gradual leakage, and detection of arrhythmia.

(4) *Division of A Major Coronary Artery*

The usual result of this event will be myocardial infarction (often with supervening fatal arrhythmia) and acute cardiac tamponade. Treatment is conservative, unless opera-

tion is necessitated because of persistently recurrent tamponade, in which case an attempt should be made to repair the severed artery if its size and nature of transection lends itself to re-anastomosis. The diagnosis may be suspected by ECG findings in conjunction with evidence of tamponade, but can be made with certainty only at operation or autopsy.

(5) *Progressive Congestive Heart Failure, Due to Rupture of A Valve or Septum*

The diagnosis should be suspected in any case with the physical findings of valvular disease or septal defect, following an episode of thoracic trauma.^{4, 6, 13} Confirmation may be elicited by the usual techniques employed in the diagnosis of congenital heart disease (angiocardiography, cardiac catheterization, etc.). Definitive operation using the technique of cardio-pulmonary by-pass should be carried out to repair the traumatic defect. Aortic valvular fracture has been successfully done by the Hufnagel valve operation.¹⁴ Control of congestive heart failure by digitalis, diuretics, and other standard measures should precede operation.

(6) *Post-Traumatic Cardiac Aneurysm*

This complication may follow seemingly mild instances of cardiac trauma.⁴ Death due to rupture of the aneurysm may be several months or years delayed. The diagnosis may frequently be made on routine chest roentgenogram, and must be made prior to rupture if the patient is to be salvaged. Surgical extirpation of the lesion, with primary closure, has been accomplished with the aid of cardio-pulmonary by-pass technique.

(7) *Intra-Cardiac Foreign Body, Resulting From Penetrating Missiles*

The diagnosis is usually made by roentgenogram, at or following the time of thoracic injury. Recent improvements in the field of intracardiac surgery probably justify the removal of the foreign body under cardio-pulmonary by-pass technique as soon as the patient's condition safely permits operation.

(8) *Conduction Disturbances*

Atrioventricular nodal block, complete heart block and other arrhythmias have been reported following blunt and sharp trauma to the chest.^{4, 5, 6} If symptomatic, these ar-

rhythmias should be medically treated and thorough appropriate evaluation of the cardiac status carried out for evidence of other cardiac damage. The drug of choice in the treatment of acute AV nodal block or complete heart block at this time is probably isoproterenol hydrochloride (Isuprel), with immediate careful digitalization.

Cardiac arrest may occur as a result of cardiac tamponade, traumatic infarction, division of a coronary artery, shock due to hemorrhage or simple contusion of the heart. If conditions permit, especially as to the availability of proper equipment and a salvageable patient, prompt cardiac resuscitation should be carried out as an absolute emergency. The problem of cardiac arrest and resuscitation presents a scope of such magnitude that for the reasons of brevity, it will be published at a later date in a separate report.

Summary

The basic surgical considerations of problems arising in the management of cardiac trauma are reviewed and summarized. A simple classification of the syndromes encountered in various types of cardiac trauma is offered as a guide to the discussion of diagnosis and treatment.

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PAPILLOMAS OF THE GALLBLADDER WITH REPORT OF A CASE*

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Definition and Incidence

In reviewing this subject for presentation, it was found that the whole entity revolved around the interpretation of a papilloma (or polyp). If one limits the incidence to true neoplasms and eliminates the other polypoid lesions, the condition is comparatively rare. It is our purpose to call to your attention the true new growth in the gallbladder, and we feel our case to be such.

Papillomas may be single or multiple, sessile (as rounded nodules) or pedunculated with stalks of varying degrees. They are usually soft, relatively small (two to four mm.) and may be obscured by viscid bile. The color is about the same as the mucosa.

Because of the inclusion of inflammatory polypoid mucosal lesions in many reports there is no definite incidence established. In 1956 Carrera and Ochsner⁸ had found 10 cases in 1103 cholecystectomies (15 cases of carcinoma) and they later¹¹ reported 28 cases in 1331 resected gallbladders. They note that 21 of these cases of gross polypoid lesions of the mucosa had been found in the last three years, probably due to their recent interest.

Kirklin¹ in 1931 was the first to diagnose a gallbladder polyp by x-ray. He reviewed the Mayo Clinic records of 17,000 cholecystectomies and found an incidence of 8.5% of papillomas. Yet in 1936, Kerr and Lendrum⁴ could find only 21 proven cases in the medical literature. Obviously, the difference lies in interpretation of lesions. Gagliardi and Gelbach¹⁰ found 3 cases in 292 consecutive

cholecystectomies and they were very careful to include only isolated new growths. Swinton⁹ in 1948 reported 7 benign tumors of the gallbladder in 4,553 operations on that organ at the Lahey Clinic. Four of these were papillomas, three were adenomas. From 1921 to 1951, 425,000 new patients were seen in the Cleveland Clinic and 8 cases had proven papillomas of the gallbladder. During this time 2,000 cholecystectomies were done and 30 cases of carcinoma were found.⁸

Pathology

The term papilloma should be limited to lesions with a vascular connective tissue stalk covered by a single layer of tall columnar cells. The stalks or villi are multiple but each is covered by epithelium. The non-papillary variety has numerous glandular structures with some cystic spaces. Both may be sessile or pedunculated.

The average size of papillomas is 2 to 4 mm. and one a centimeter in diameter is considered large. Kerr and Lendrum⁴ report a polyp 5 cm. in diameter which was palpable abdominally. They are usually small and often so fragile that palpation or instrumentation will break them off.

Papillomas occur with and without stones and usually when no stones are present the gallbladder functions normally by the present test methods. Shepherd⁵ found stones in 68% of the Mayo series, Kane⁶ found stones in 3 out of 8 cases. Tabah and McNeer⁷ had 2 in 4 and Carrera and Ochsner⁸ found stones in 5 of their 10 cases of papillomas.

The mucosa in the gallbladder varies greatly from smooth flat to villous-like formations

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with a velvety appearance. In cholecystitis there is hyperplasia of the mucosa with development of new glands and a heaping-up of mucosal folds giving a polypoid appearance which may even be seen by x-ray examination. Normal villi in the gallbladder may enlarge and become infiltrated with cholesterol deposits. These resemble polyps, when large, but are not true tumors. If small they resemble small stones in the mucosa and are often called "strawberry gallbladders". Another condition similar to a papilloma, occurs in chronic cholecystitis where the epithelial proliferation results in a downgrowth into the mucosa and muscularis (Rokitansky-Aschoff sinuses). Adenomyoma and "cholecystitis glandularis proliferans" are other names.

The question of the relationship of true papillomas to carcinoma was foremost in our investigation. Even though there are reported cases of *carcinoma in situ*, I have been unable to find a case of invasive carcinoma reported.

Carrera and Ochsner¹¹ reported carcinoma in one of the fronds of a large pedunculated papillary adenoma with no evidence of invasion of the base. Tabah and McNeer⁷ at the Memorial Hospital in New York feel that there is a definite malignant tendency in papillomas and have found *carcinoma in situ* in three of their four cases reported. In general, the feeling seems to be that true papillomas are precursors of carcinoma and that in itself warrants cholecystectomy. There does not, however, seem to be the pre-malignant tendency of gallbladder papillomas in comparison to those in the gastro-intestinal tract and bladder.

Diagnosis

Papillomas (polyps) of the gallbladder are usually diagnosed by x-ray examination. They may be entirely asymptomatic but symptoms of chronic cholecystitis are most common. All of the three cases reported by Gagliardi and Gelbach¹⁰ had typical gallbladder symptoms and were relieved by cholecystectomy.

Kirklin's¹ first criteria for x-ray diagnosis are still applicable. He described the constant position of radiolucent shadows in the erect and recumbent positions. The tumor is fixed to the mucosa and unless the stalk is long it will bear the same relationship to the organ in all positions. They are usually smooth and

round and are best seen in a partially filled gallbladder. It is surprising how polyps 2 to 3 mm. in size can be seen with good x-ray technique. The reason is that the organ is usually small, it functions normally, takes the dye readily, contains some fluid and the lesion has a smooth contour.

Moore³ suggests taking the films tangentially, trying to get a profile of the lesion and producing a "notch" in the outline of the gallbladder. Multiple lesions more nearly simulate stones. It is necessary to always have films in at least two positions and if a constant radiolucent shadow is seen, the test should be repeated after several days. If then seen again, the shadows are probably papillomas.

Papillomas may cause symptoms of acute or chronic cholecystitis. Lund and Burman⁶ report a case where a pedunculated papilloma passed into the cystic duct and produced acute disease. Henry² found papillomatous implants in the cystic duct causing obstructing. Oakland's⁹ case presented a normally functioning gallbladder with symptoms of chronic cholecystitis. X-rays showed constant radiolucent shadows with opaque material only partially surrounding them. The opened gallbladder had multiple polyps 4 to 10 mm. in height and no stones. The symptoms disappeared after cholecystectomy. Carrera and Ochsner¹¹ warn against not removing the gallbladder when one feels that polyps are there by x-ray. Many times the polyps cannot be palpated and will be found on opening the removed gland. Palpation may fracture the stalk and make it even more difficult to feel the soft lesions. Several authors^{8, 9, 10} have reported relief of symptoms from cholecystectomy for papillomas without stones. Grego and Hawkins⁵ report a patient with a diagnosis of chronic cholecystitis and radiolucent x-ray shadows. Polyps were suspected but could not be palpated. After removal of the gallbladder, three papillomas were seen with stalks 0.5 cm. long. The patient's symptoms were relieved. Coincidentally, this patient also had benign rectal and sigmoid sessile excrescences which were fulgurated.

Case Report

Our case is one of a colored female, age 57, who was examined in the office of one of us (A. I. J.) and admitted to the Good Samaritan Hospital on July 23.

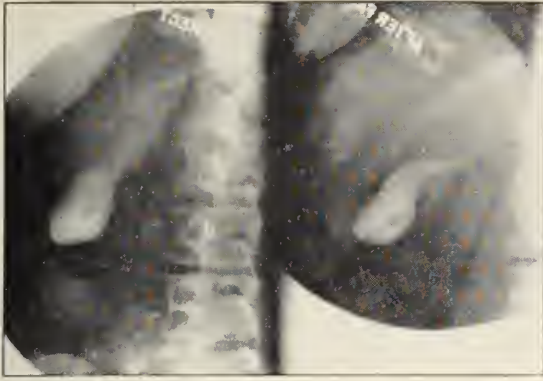


Figure 1

Showing papilloma in fundus of gallbladder in essentially the same position in the erect and recumbent posture. Diagnosed as such preoperatively by radiologist.

1957 for cholecystectomy for a papilloma. She had typical symptoms of chronic cholecystitis with "indigestion", belching, gaseous distention and some right upper quadrant discomfort. Dr. George Smith at the Columbia Hospital had made the diagnosis by x-ray and the day after hospital admission, the patient was operated upon under spinal anesthesia. A right subcostal transverse incision was made and the abdominal examination was essentially negative except for a small, smooth, soft, normal appearing gallbladder with a soft mass felt near the fundus. After removal, the mass proved to be a pedunculated papilloma about one cm. in diameter and on a distinct stalk about 0.5 cm. long. The polyp was velvety to feel, greyish-brown in color and had a hematoma on its end where it had been injured by palpation. The patient made an uneventful convalescence and has been free of symptoms since operation.

The tragic part of this story now unfolds. In an attempt to get the fresh specimen (in saline) photographed at the Columbia Hospital, there was a pro-

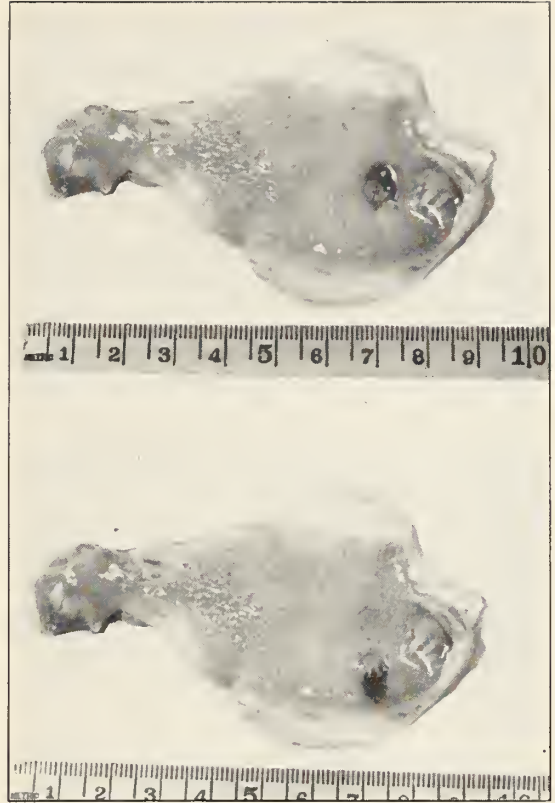


Figure 2

Showing two positions of papilloma in fundus of gallbladder. Stalk was about 0.5 cm. long—lesion 1 cm. diameter.

longed delay in getting it to the pathologist's private laboratory. I feel there was a mishap there also for his report to us was delayed. The saline was apparently never changed and the organ underwent autolysis. Grossly the tumor appeared to be a true pedunculated villous papilloma.

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THE IMPACT OF MENTALLY ILL CHILDREN UPON THEIR FAMILIES*

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The complete detailed report of this study which required a year of intensive research, comprises some two hundred typewritten pages to be published in the future. Within the space of the present article, one can select only a few of the outstanding findings and impressions.

The objective of this study was the attempt to determine the consequences for the family of the fact of a mental disorder in a child of sufficient severity as to necessitate its institutionalization. This particular aspect of the problem has heretofore been a relatively neglected area in the field of child psychiatry. A large majority of the previous studies of the families of emotionally disturbed children have been devoted to the determination of the familial forces which may have contributed to the origin and perpetuation of the disorder.

"The ways in which a family might cope with the problem of mental illness are not pre-defined for them by established cultural patterns, as they are in most forms of physical illness. Uncertainty with regard to what is wrong, what one 'should' do, what other people will think, whether a given course of action will be effective, and just how it will all turn out are constant features of the situation. It is a situation without norms or guides for appropriate action, even from experts. Perhaps the only relatively defined aspects of the problem is the knowledge by family members that mental illness in our society carries a social stigma." (Quoted from the report of the principal investigator, Dr. Lenore Korkes.)

Since cases of somatic pathology, organic brain disease, epilepsy and mental deficiency

present a wide variety of different problems to the family and although they deserve and invite a similar type of study, they were ruled out in favor of limiting this investigation to the families of children who had been diagnosed either as schizophrenic-like or serious behavior disorders. Moreover, this limitation would be in the interest of uniformity and also would avoid as far as possible the frequent tendency in a family to insist that the disorder is not a "real" mental illness.

In addition to selecting children who had received a diagnosis of mental disorder to the exclusion of any detectable organic pathology, the criterion of studying only those from families consisting of the biological parents and siblings and who had maintained a joint residence was adopted. Therefore, the factor of "broken homes" was excluded. The reason for this is obvious since the impact of a child's illness on a home that is already disorganized as a unit would present additional factors for evaluation.

One hundred parents (or fifty families) participated in the study and there was a high degree of cooperation. Of the children in the hospital the age range was four to fifteen years, the time in the hospital at the time of the study ranged from four months to eight years. Seventy-five per cent of all the patients were boys.

Each parent who participated in this study was interviewed privately. All but seven per cent were interviewed at their homes. The duration of the interviews ranged from three and one-half to seven and one-half hours; the average time taken was four and one-half hours.

All the interviewers were persons professionally employed in the fields of social work, psychology and sociology, with considerable skill and training in the technique of the intensive, non-directive interview. None of the inter-

*An abstract of a report on a project carried out in the Department of Research in Neurology and Psychiatry of the Department of Institutions and Agencies, State of New Jersey.

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viewers had any direct connection with any of the families seen; all represented themselves to the parent as a person connected with a project sponsored by the Department of Institutions and Agencies. Thus the interviewer was, to the parent, an "outside" but interested party; the reassurance of complete anonymity was given to all.

A series of open-ended questions were designed to cover the following areas: (1) attitudes toward the hospital; (2) the theories of causality and notions of possible prevention; (3) the perception of and current interactions with the patient; (4) the problems involved in the decision for institutionalization; (5) the perceived impact upon the patient's siblings; (6) parental changes in behavior towards the sibling; (7) the parent's own idea of the impact upon his or her self; (8) the impact upon the marital relationship; and (9) the effects upon social behavior and communication with others.

A brief summary of the four types of parents is presented below based entirely upon the criterion of the way in which the illness is defined as to its origin. The parental expectation for cure is highly related to these definitions.

General Types of Families Formulated

Type I. "*Dissociative*": Etiology of the illness is perceived to be *solely* in an organic, fixed condition, whether already present at birth or due to some fortuitous event such as an accident or physical illness. There is little or no expectation for recovery or even substantial improvement. Describes 38% of the total sample, 38% of Fathers, 38% of Mothers.

Type II. "*Confounded*": Several notions of etiology maintained simultaneously without any certainty that any one is valid. The multiple theories are usually not integrated. Parents of this type believe there may be an organic factor and also wonder if there is an interpersonal factor. This type shows the greatest degree of *uncertainty* in their attempt to define the illness situation. It is also the most heterogeneous of the four sub-types, including (a) parents who *wonder* if perhaps they have in some (unspecified) way contributed to the disorder (b) those who *wonder* if their hus-

band or wife has (c) those who *wonder* if the school or neighborhood experiences have added to the difficulty, in addition to the possible organic factor. Usually, they have quite limited expectations for recovery, but as a group are somewhat less pessimistic than Type I. Describes 22% of the total sample, 23% of Fathers, 21% of Mothers.

Type III. "*Extra-punitive*": The cause of the disorder is attributed to *persons other than the responding parents*. School and neighborhood influences are most frequently mentioned. Also included are other relatives of the patient (e.g., grandparent, sibling). The essential distinguishing point is that the parent, although noting an interpersonal source for the difficulty, does not feel in any way personally responsible. Generally these parents anticipate marked improvement and the return of the patient to the family. A number of these parents tend to minimize the seriousness of the problem. Describes 20% of the total sample, 27% of Fathers, 14% of Mothers.

Type IV. "*Affiliative*": Etiology is perceived as rooted, at least in part, in the familial atmosphere and the parent's own behaviors and attitudes. Included are a number who may *also* question the role of organic factors or extrafamilial psychosocial influences. The distinguishing criteria for inclusion is the acceptance of some level of responsibility, even though the degree varies. Prognoses made by parents in this group tend to vary from modest expectations of some improvement to high hopes for recovery. Describes 20% of the total sample, 12% of Fathers, 27% of Mothers.

Summary of Findings

Family members of mentally-ill patients may be considered as persons in a stress situation, wherein much of the power to control the source of the difficulty is not generally perceived to be in their hands. Since in the nature of the case, parents of patients do not see themselves as fully able to change the child, they must develop some technique for coming to terms and living with the situation for a more or less extended period of time.

There are no special societal norms which would aid the parent in coping with the situation. There is a lack of general knowledge of

both "correct" and effective parental action. The current status of expert opinion on this question is unclear, so that the parent cannot simply take some authority's idea as a guide to action. Seven out of every ten parents interviewed state that they arrived at their notion of the etiology of illness on their own. This situation permits of a wide range of possible interpretations of the illness.

Among the significant meanings of the total experience is that parents find themselves occupying a new and undesirable status, "parent of an emotionally or mentally ill child". This status connotes certain internal and interpersonal changes. There is the deprivational aspect: as some of these parents have lost the anticipated pleasures of rearing a normal child; many also have "lost" the rewards of relatively free communication with their mates and with the community. The parent in such a situation usually feels somewhat excluded from the "normal" community. Especially for those parents who do not anticipate a recovery, there is an underlying sense that there is no escape from the problem. In this respect the parent of a child seen as hopelessly ill is under a *prolonged* stress, in contrast to the situation of a bereaved parent.

The Type I parents ("dissociative") may sometimes actually resolve the stress situation by no longer including the patient as a family member in their thinking, an adaptation analogous to that of a bereaved parent.

The data show that the emotional climate of the marital relationship is altered by the illness and hospitalization for the vast majority. The degree and form of the alteration seems to be related to the way in which the situation is defined and, in turn, met. There is evidence that the majority feel liberated from the stress created by the patient as a consequence of the institutionalization; further, half of the parents report a decrease in domestic disputes. In this atmosphere, there is the opportunity for parents to re-evaluate their attitudes toward themselves, the patient, and their family life. It was noted that when the parent acknowledges some degree of responsibility, he or she is most likely to attempt a reconstruction of these attitudes and relationships. The capacity for communication would seem to be both

cause and effect of the reported changes in personal and social adaptation. The definition of the illness as in part arising out of the interpersonal situation in the family is one which may create more tension during an early stage of the appraisal process. However, it would seem that parents who adopt this definition have the greatest chance of enriching their familial life as a result of the total experience, and the patient, if and when discharged, might actually return to a better family situation than the one he left.

Those parents who define the situation as due to some fixed, organic factor, and those who perceive the illness as stemming from extra-familial psychological forces, may be considered similar with respect to the underlying externalization of all responsibility. This study was not concerned with the veracity of such interpretations, but rather with the consequences. During the hospital stay, it would seem that parents who "externalize" the cause of the illness in some constitutional agent often feel drawn somewhat closer to their mates, due to the common fate to be endured. There is little or no mutual recrimination. Feelings of personal guilt are minimized by such an interpretation. There are, however, dysfunctional features to such an interpretation; should the patient improve and be sent home, even temporarily, the parents will tend to have no insight into his needs, and generally feel emotionally alienated from the child.

When those parents who consider the illness as due to the behavior of persons outside of the family are examined, it is found that one correlate of this definition is that the parents do not feel extremely alienated from the patient. For example, the patient tends to be perceived as capable of comprehensible emotional response; in contrast with the Dissociative Type, more of these parents tend to feel they have some current role to play in the child's development and do *not* tend to reduce the amount of discussion of the patient in the home. The ascription of all responsibility to other persons, however, does not require the parent to re-examine his or her own attitudes and relationships. Consequently, although these parents do not feel "alienated" from the patient, the majority do *not* change anything

fundamental in their child-rearing beliefs, or in their self-knowledge. Parents of this type almost never report an improvement in the basic marital relationship. On the contrary, they are most likely to report a strained and distant relationship, and are second only to the uncertain parents of Type II in the frequency of reports of *increased* distance between husband and wife as a consequence of the institutionalization.

These findings, and the possible implications, point up a need for increased, intensive social service facilities for the families of children in mental hospitals. Parents can be helped to explore their own feelings under professional guidance so that some of the released affects will not be overwhelming. Both mother and father should be given these services in order to increase the capacity for communication and joint evaluation of the total experience. Professional workers who deal with the families of patients have to be particularly concerned to involve the father as well as the mother in any reconstruction efforts. Not infrequently one finds instances where the patient's mother either assumes some share of responsibility for the disorder, or is concerned about a possible contributory role, while the father tends to minimize or deny any awareness of personal responsibility. In these cases, the mother may wish to seek professional help, but is reluctant to do so without the participation of the father in the process. Or, we may note several families wherein the mother is attempting to reorganize the family atmosphere without benefit of professional aid, but feels frustrated as a result of the father's relative lack of interest in this goal. This study indicates that when such joint reappraisals are made, the families of mental patients may in fact become reorganized so as to be more integrated than they were prior to the institutionalization. It is also suggested that in this way an atmosphere may be created in which the patient, pending improvement, could become re-assimilated.

The differential impact of mental illness in a child upon the mother in contrast with the father is in part to be understood in terms of the greater contact which the mother has had with the child. The mother's status and feel-

ings of gratification or thwarting are more closely tied to her parental role. These generalizations can be documented by the findings that 61% of the mothers, but only 35% of the fathers report that the events surrounding the child's illness produced the greatest degree of tension in the parent's entire life span. Also, whereas mothers are likely to emphasize the child's illness and child-rearing problems in general as the most troublesome aspect of their parental role, 33% of the fathers refer to financial problems (and only seven per cent of the mothers) as the most troublesome aspect. The father is not as oriented toward his parental function; this factor helps explain the finding that over one-quarter of the fathers, (but only seven per cent of the mothers) say they have not really been affected by the child's illness. In contrast, mothers frequently describe intense affective disturbances, including depression, guilt, wish for withdrawal and even "nervous breakdowns". Mothers are more likely than are fathers to explain their affective reactions to the illness and hospitalization by invoking the idea that such reactions are "natural", stemming from the fact of being the patient's parent. An explanation of affective reactions to the situation which is unique to fathers is that they have been deprived of a pleasure; (14% of the fathers, and no mother stated, "Well, I just like kids," or "I enjoyed having him around").

Mothers are more likely to perceive signs of disorder at an earlier age than are fathers. Having perceived some sign of difficulty, fathers are more likely to initially react by regarding the symptoms as within the normal range of behavior. The child will be seen as an amusing cut-up, a bit wild, or maybe just a little slow in development. Once the fact of a disorder has been recognized, we find that fathers and mothers differ with regard to their needs for aid in deciding upon institutionalization. Fathers tend to emphasize the factual and action aspects, i.e., getting information and expediting the whole procedure. More salient for mothers are their emotional needs for support at this point. Particularly, mothers are oriented toward receiving such emotional support from their own parents.

Mothers are more likely to implicate themselves in the development of the disturbance; they also tend to be more aware of hostile and ambivalent feelings directed toward themselves in the patient. The current role the parent might play in the child's adaptation is also more salient for mothers as a group. Consonant with the greater frequency of concern over some responsibility for the illness, is the finding that mothers are more likely to report considerable change in their child-rearing practices, and in their own attitudes toward their normal children. The majority of the mothers of patients (in contrast with approximately one-third of the fathers) have thus learned to perceive their relationship to their children in new ways.

That the mother of a patient in a mental hospital is more likely to feel some responsibility for the disorder, to have intense affective reactions, and to be mobilized to form new perceptions of the self in relationship to children than the father may in itself create some strain in the marital relationship. One index of this disparity in reactions is that while 78% of the fathers stated that their wife was one of the two "easiest" persons with whom they could discuss the illness, only 51% of the mothers of patients so described their husband.

If, as has been indicated in the current investigation, the way in which the family member defines the illness may have such far-reaching implications for personal and intra-familial adaptation, and implicitly for the patient, it would seem important to search for possible determinants of the particular definitions. The four-fold typology described above has been found to be independent of the following variables: economic class, education, birth order of patient and religious preference. The typology is also relatively independent of the length of hospital stay; there is only a slight trend for parents of children who have been in hospitals for four or more years to be described as "Dissoeiative" or Type I.

We have no really adequate data on the marital relationship prior to the onset of the illness, but only the retrospective accounts. However, the following hypotheses are suggested by these reports:

(1) Marriages already characterized by a

high degree of conflict together with both a lack of affection and communication are likely to emerge from the illness experience in more disturbed forms.

(2) Even in the absence of overt conflict, marriages in which there is little communication are unlikely to become reorganized in a reconstructive mode.

(3) Families who may be described as economically and socially marginal are likely to become even more disintegrated as a consequence of the illness. Included here are cases where the father is a casual laborer where the family has no real relationship to an immediate or larger community, and where in the extreme we find demoralization.

(4) Families in which there is a basic orientation to a system of values, whether religious or humanitarian are more likely to cope with the situation with minimum disruption.

The detailed study of the families of schizophrenic-like children impresses one that mothers certainly do not cause all of the disorders attributed to them by some writers. It is found that many of these children have an original constitutional susceptibility to the normal vicissitudes of life. That it does require a certain type of home environment to produce schizophrenia (the number one health problem today) is far from a proven fact. There is now more evidence that the disorder is constitutionally determined. The following questions require an answer through additional extensive research. Are serious personality problems present in the parents of all mentally ill children without exception? If this is found to be a fact, are there other children who are normal in the same family and how explain the difference? How many parents with normal mentally healthy children have been checked in control studies to ascertain how many of these parents have personal difficulties of some or of equal seriousness? Has the sick child caused or aggravated a family problem? Has the child precipitated a neurosis in the mother?

It is obvious that there can be no reliable pronouncements on these issues until they have been more thoroughly investigated by a scientific approach, but it is hoped that the topology suggested in the present study will

be found useful as a tentative model for other researches in the area of adaptation to stress. This topology might lend itself to somewhat

similar problems such as the impact of juvenile delinquency, mental deficiency or physical deformity upon the family unit.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Paroxysmal Atrial Tachycardia

DALE GROOM, M. D.
Department of Medicine

Case record—For the first week after birth a female infant was observed to have a regular but rapid pulse which occasionally would decrease spontaneously to a normal rate. Several electrocardiograms recorded during these episodes of rapid heart action disclosed the arrhythmia to be paroxysmal atrial tachycardia with rates ranging from 180 to 200 beats per minute. Efforts to slow the rate by such maneuvers as carotid sinus stimulation, induced gagging, and pressure on the epigastrium were unavailing. However, following digitalization the pulse rate declined to 100 and a repeat tracing revealed a normal sinus rhythm.

The same tachycardia recurred in association with a febrile illness the second week. On this occasion additional drugs were tried, including quinidine which in a test dose produced a hypersensitivity reaction, and procaine-amide and prostigmine which were ineffective. The electrocardiogram illustrated here was recorded after administration of an increased dosage of digitalis when it was observed that the pulse rate could be made to drop abruptly to 140 by pressure on the carotid sinus. By the third week the tachycardia abated, a normal sinus rhythm was evident in the ECG, and the baby was discharged on a maintenance dose of digitalis. Close observation during the ensuing two months revealed no recurrence of a cardiac arrhythmia.

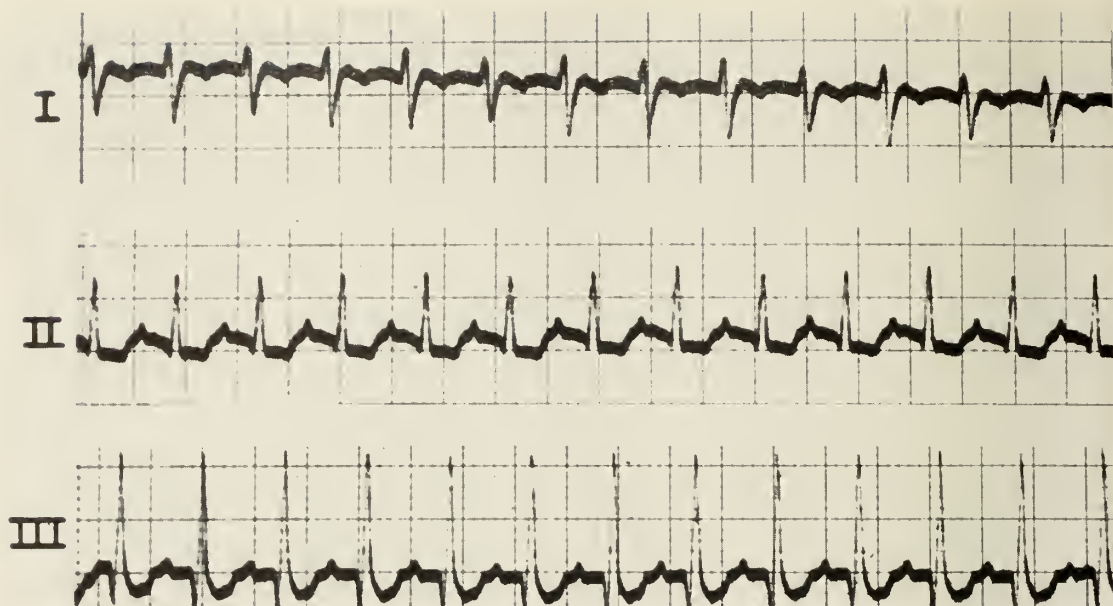
Of special interest in this case is the presence of a tachycardia before birth. The obstetrician had expressed some misgivings over his finding of a fetal heart rate of 180 or above on all prenatal examinations the last two months of gestation.

Electrocardiogram—The rhythm is regular at a rate of 190. At first glance it might appear to be a normal sinus mechanism in that the P waves, which are well deflected in standard leads II and III, are not grossly abnormal. Their contour, however, differs sufficiently from that in other tracings recorded when the tachycardia was not present, to demonstrate an ectopic

origin of the pacemaker in this electrocardiogram. All P waves are partially fused with the preceding T waves but the P-R interval can be measured approximately as 0.16 sec. The QRS complexes are normal and show the right axis deviation which is expected at this age. Also normal in infancy is the observed inversion of T waves. There is a suggestion of digitalis effect in the downward slant or "sagging" of ST segments in leads II and III.

Discussion—One of the most common and generally innocuous arrhythmias is that of paroxysmal atrial tachycardia. Characteristically it is an intermittent tachycardia, beginning and ending abruptly, lasting several minutes to several hours, occurring at any age but said to be more frequent in the second and third decades of life. Its rhythm is usually regular. Seldom does its rate vary more than 20 beats above or below 180, although rates up to 250 and more have been reported.

Much remains to be learned of the basic mechanisms involved in this and the other ectopic tachycardias. The constancy of rate and regularity of rhythm typical of paroxysmal atrial tachycardia have been cited as evidence of a single circus type of excitation wave perpetuating itself in the atria. Another theory, that the tachycardia arises from a series of rapid and repetitive discharges from an ectopic focus, relates it more closely to the other atrial arrhythmias. In this view "P.A.T." is regarded as essentially a mid-stage between atrial premature contractions and flutter, the end stage being the chaotic activity of atrial fibrillation and the distinguishing difference being that of rate. Quite possibly there may be more than one mechanism of the arrhythmia. Recent work has suggested that a type of paroxysmal atrial tachycardia which is associated with a variable degree of atrioventricular block, is usually attributable to digitalis toxicity and manifests a somewhat different clinical behavior may be a separate entity. Regardless of the mechanism, the P waves in P. A. T. have an abnormal configuration which is determined by their site of origin in the atria. An ectopic location close to that of the normal pacemaker may produce P waves indistinguishable from those of a normal sinus rhythm. This particular tracing was selected because the P waves, on which rests the diagnosis of an atrial tachycardia, are clearly defined. Often they are obscured by the preceding T waves and



their presence can be demonstrated only by an esophageal lead or, perhaps, a precordial lead recorded from the area of the 3rd intercostal space near the right sternal border. In this way P. A. T. can be differentiated electrocardiographically in most instances from sinus tachycardia, atrial flutter, or an A-V nodal tachycardia. Without this differentiation, the arrhythmia is simply classed as a *supra-ventricular tachycardia*.

As a rule the QRS complexes are normal because conduction below the A-V node is normal. An exception is the slurring, notching, or widening of these complexes ascribed to "aberrant ventricular conduction" which occurs with more than the ordinary degree of frequency in sustained supra-ventricular tachycardias. More often there are T wave changes which become especially pronounced when the paroxysms are prolonged. Inversion of T waves and even considerable depression of ST segments in the left precordial leads may develop during attacks and are thought to be due to myocardial "fatigue" or actual ischemia.

The abruptness of the onset and termination of a paroxysm of atrial tachycardia and the regular pulse rate of about 180 unaltered by exertion or rest are important features of the arrhythmia, as is its response to treatment. Many of these patients complain of dyspnea or a smothering feeling, of vague aches or pains in the left chest, of weakness or sweating or apprehension. Cerebral symptoms of dizziness or syncope are not uncommon. The sudden awareness of palpitation may evoke considerable anxiety or panic, particularly if the patient is unaware of the nature of his attack. Other individuals experience only a mild precordial consciousness, or no symptoms at all. Paroxysms which go on for days or weeks, or ones

which entail very rapid heart rates, can produce angina pectoris, congestive failure or, rarely, shock. One should always strive to obtain an electrocardiogram during an attack, if only because of the reassurance this diagnosis affords to the patient.

Most cases of P. A. T. which come to the attention of the physicians have no demonstrable cardiac disease. In those who are prone to recurrences such factors as emotional stress, fatigue, anxiety, or febrile illness can often be identified as instrumental in precipitating the attacks. Occasionally this arrhythmia is seen with acute myocardial infarction, thyrotoxicosis or myocarditis. Paroxysmal supra-ventricular tachycardias are part of the Wolff-Parkinson-White syndrome; patients with this anomaly of atrioventricular conduction may present themselves with tachycardia as the only clinical manifestation.

Attacks of P. A. T. which do not subside spontaneously within a few minutes and which do cause disturbing symptoms should be treated. The patient himself often learns to abort attacks by holding his breath, by attempting to inhale or exhale against a closed glottis, or by leaning forward with the head down or simply relaxing in the supine position. The standard maneuver of stimulation of a carotid sinus by pressing it against the cervical spine and massaging it lightly for 10 to 20 seconds yields dramatic results in some cases and is reasonably safe in all but elderly patients. Usual procedure is to press first on the right carotid sinus and then, if no results, on the left, at the same time listening to the heart sounds or carefully noting the pulsations in the vessel for an abrupt drop in rate. Other methods which presumably induce vagal depression of atrial activity are those of making pressure on one or both eyeballs, on

the epigastrium, or induction of gagging by stimulation of the posterior pharynx.

The depressant action which quinidine exerts on myocardial irritability has proven useful in both treatment and prevention of paroxysms of atrial tachycardia. A few individuals have an idiosyncrasy to the drug—hence the advisability of administering a test dose of 0.1 or 0.2 gram first. For therapy in the adult, quinidine sulfate can be given orally on a schedule of 0.2 to 0.4 gram every 3 hours, or up to every 1-2 hours in extreme cases, until the tachycardia subsides or cinchonism appears. Larger initial doses of quinidine are preferred by some cardiologists. The danger attending administration of more than 3 grams or so in a 24 hour period can be minimized by frequent electrocardiographic observation for signs of quinidine toxicity. Maintenance doses of as little as 0.1 gram every 3 or 4 hours will prevent ectopic arrhythmias in some patients. Drugs often used as second choice in P. A. T. are prostigmine, Mecholyl, and neosynephrine. Procaine-amide is generally less effective in atrial than in ventricular ectopic rhythms.

It is paradoxical that digitalis can both cause and

suppress paroxysmal atrial tachycardia. Enough cases have responded to digitalis after having proved refractory to other methods of treatment that this drug is preferred by some, whether congestive failure is present or not. It would of course be contra-indicated in P. A. T. with block or in any other situation in which there were reasons to suspect that the arrhythmia might be caused by digitalis toxicity. For this application the intravenous route of administration is often used to bring about a prompt response. A total dosage of 1.2 to 1.6 mgms. of a lanotocide-C preparation such as Cedilanid, divided into 2 injections given over a period of a day or less, is an average dose for full digitalization of an adult. Other general measures such as sedation, rest, and reassurance are helpful. Abstinence from tobacco and caffeine is reputedly of value in reducing the frequency of attacks of some cases.

The occurrence of paroxysmal atrial tachycardia in utero—or at least its persistence there over a long period of time as presumably occurred in this case—is doubtless exceedingly rare.

Report of Mr. William Sandow, Jr.,

Executive Director,

SOUTH CAROLINA MEDICAL CARE PLAN,

**to the ANNUAL MEETING of the
CORPORATION, Myrtle Beach, S. C.**

May 14, 1958

MR. PRESIDENT, Corporate Members of the South Carolina Medical Care Plan, and Guests:

I am, once again, very happy to have the opportunity of reporting to you, the chief governing authority of the South Carolina Medical Profession's Blue Shield Plan.

I sincerely hope that you will look upon me, not as the representative of some remote third party entity purchasing your services for re-sale to the public, or, as the representative of just another insurance company, but rather as an employee of your organization—an organization existing only to help you facilitate the provision of your services to the people of South Carolina.

I wish that I could report to you a year of outstanding success in terms of greatly increased enrollment under broader benefit contracts with corresponding financial gains, however, such is not the case.

I am sure that you will be concerned to learn of a year that was marginal both as to finances and growth, despite considerably more new enrollment than has been obtained for several years previous, despite increased subscriber's rates, and despite further reduction of already limited benefits.

Rather than belabor our particular problems I should like to take a few moments, and I assure you I shall be brief, to consider generally prepayment for

health care — of which Blue Shield is an important part. Such an analysis will, I hope, be meaningful by pointing up some basic circumstances which in turn manifest themselves as specific problems.

There are many unresolved questions in the field of prepayment for health care. For the most part, however, these unresolved questions are in the methods for accomplishing an agreed upon objective and in the rate at which the objective will be obtained. Essentially, the objective of voluntary prepayment is to cover as many of those costs of illness as is possible that individuals may incur which cannot be met "out-of-pocket" at the time of need.

From the point of view of the patient, or the person responsible for the patient, this means knowing that in the event of an illness in the family, the costs of needed care will not disrupt the family's finances.

Of course, there are, depending on the point of view, certain by-products in the attainment of this objective by voluntary prepayment which may seem to supersede in importance the objective itself — and perhaps properly so. These can be variously stated as helping people to meet the costs of health care and at the same time maintaining a free enterprise system among those who provide the care; or, permitting health services to be bought and sold on a voluntary basis within the framework of a credit economy; or, permitting the providers of health services to compete for a share of the consumer dollar against the demands for that same dollar by other goods and services.

I think we can agree that such an objective is worthwhile, but, you may well inquire, is this mechanism necessary? Let me give you a few facts—

In 1955, which was a prosperous year by any standards, about 48% of all families in the United

States had incomes below \$5,000. About four million—or approximately 9% of all families had incomes of less than \$2,000. More than one-third of all farm families had incomes of less than \$2,000. In South Carolina we estimate the percentages under these incomes to be somewhat greater.

Of even more significance is the fact that in early 1957 one-quarter of all American families had no cash savings. More than half had less than \$500. Only one-fourth had savings of \$2,000 or more. Furthermore, consumer credit, relative to the size of consumer income after taxes, is now double what it was a decade ago. At the present time it is estimated that almost 20% of all incomes after taxes is pre-committed to family debts, either mortgage or other instalments.

All of this means — what I am sure you must realize — that in the present economy of this country most Americans must make most major purchases, especially health care, which by and large is impossible of anticipation, on a pre-paid basis.

How well is the prepayment job being done in the face of this obvious need? Despite the almost fantastic growth of prepayment and insurance in the past two decades, there remains much to be accomplished:

Nationally, roughly 50 million people, one-third of the population, have no prepayment for or insurance against any kind of hospital bills. Seventy million have no prepayment for or insurance against any type of surgical care. Two out of every three persons, almost 107 million, lack prepayment for or insurance against general medical expenses. What is even perhaps more significant and alarming is that even under existing enrollment, still less than one-third of America's total private health bill is either prepaid or insured.

In South Carolina slightly over half of the population has some insurance against or prepayment for hospital expense. Of this number, about one-fifth have prepayment through Blue Cross. This one-fifth incidentally probably receives close to one-third of the total benefits provided on either an insured or prepaid basis — which is one measure of the value of Blue Cross as compared to the rather poor commercial imitations. For surgical expense slightly less than half of the South Carolina population has some form of protection of which roughly 15% is Blue Shield. For general medical expense about 14% have some protection of which well over one-third is Blue Shield. In the realm of payments provided, Blue Shield's 15% pays probably better than 25% of the total for surgical expense and its one-third of the medical care better than 40% of the total. I would suggest by this measure at least our benefits are not to be too severely censured. Not capable of measurement in monetary terms, of course, is the value to the public of Blue Shield's unique "service" feature.

Why is prepayment — and more particularly Blue

Cross and Blue Shield, not doing a better job in expanding benefits and enrollment until there is coverage for everyone for all the costs of health care which cannot be managed at the time of illness without financial jeopardy or at best dislocation — especially since the larger the bill for an illness the more important it is to have the last dollars of illness expense covered — not only for hospital; in-hospital medical and surgical care but for other essential health care, particularly essential out-patient services that must enter into the picture?

The answer is this — the rate at which benefits can be expanded depends almost entirely upon public willingness to allocate larger sums to voluntary prepayment. And I should like to interject at this point that gaining this public willingness is a particularly unique and difficult sales problem. For, by and large, we are dealing with people in good health who do not anticipate needing care and even have a psychological aversion to considering the possibility of need. In our case, the old saying — "The Devil sick the Devil a Saint would be" does not apply. Believe me, prepayment dollars are hard to come by.

Faced with the economic dilemma of rising public demand for health care and rising unit costs of care — since the war, health care costs have risen faster than almost any other item, and are now about 20% higher than the average of all items, — and, since health care costs have risen much faster than consumer incomes, prepayment agencies have found it difficult to increase benefit levels as fast as would seem socially and economically desirable without jeopardizing public willingness to buy. The public, generally, has not sufficiently understood the underlying economics of prepayment financing to be willing to meet the rising price structure for protection resulting from higher unit costs of health care, and, at the same time meet the higher price that accompanies higher benefit levels and rapidly expanded use of benefits now existing. The result has been — and I would ask you to note this point well — a retarding of the expansion of benefit levels for items other than hospital care occasioned by the rapid rise in the cost of prepayment for hospital care itself.

I would like to repeat this — the result has been a retarding of the expansion of benefit levels for items other than hospital care occasioned by the rapid rise in the cost of prepayment for hospital care itself.

Of course, you can appreciate that in the cost of prepayment, amount of use is perhaps more important and certainly less predictable than unit cost *per se*. I might interject, at this point, that this is, to us, a very real consideration — for we are now in the process of making another major increase in Blue Cross rates, the necessity for which is almost entirely the result of greatly increased use, 2100 more admissions than for the same period last year and over \$200,000 added expense. Let me illustrate the benefit curtailing effect of this factor:

The general public in South Carolina has a rate of 124 hospital admissions per thousand people. Nationally, Blue Cross and Blue Shield members have an admission rate of 136 per thousand. South Carolina Blue Cross and Blue Shield members have an admission rate of 169 per thousand. This means that South Carolina Blue Cross and Blue Shield members go to the hospital about 20% more than the national average for all other Plans, and compared to the general South Carolina population, 30% more often. These figures, of course, do not take into account cost per admission which is a direct function of services ordered. I might add that we have evidence which indicates the situation in Blue Shield is roughly the same and in the same proportions.

In 1957, last year, South Carolina Blue Cross and Blue Shield distributed its members' prepaid funds in the amount of about \$4,942,000. Considering the 20% differential in admissions between the South Carolina Plans and the national average of all plans, there is more than \$980,000 of our members' funds being spent for hospital-surgical and medical care than would have been spent were rate of use at the national average.

This would buy for all South Carolina Blue Cross and Blue Shield members at an average utilization rate

- a) a \$350 surgical fee schedule
or
- b) a \$10 first day and \$5 for 119 days in hospital medical care benefit plus all necessary outpatient diagnostic work-up and consultation
or
- c) all post-hospital medical care, nursing care, and medicines in prolonged illness cases under a major medical care contract.

If South Carolina Blue Cross-Blue Shield members used the hospitals at the same rate as the general public of the State, there would be at least an additional half million dollars of their funds available for other benefits. If this were the case any two of the previously mentioned additions to the prepaid health care of our members could be made available.

To put it another way, the \$31 per year now contributed as prepayment by each Blue Cross-Blue Shield member could be reduced to \$22 and still maintain the present benefit levels were utilization rates the same as for the general public; or, no more than \$25 if utilization rates were at the national average of all Blue Cross-Blue Shield members. Of the \$4,942,000 paid out for Blue Cross and Blue Shield benefits in 1957, 28% was paid for physicians' services. In 1958, because of increased costs and use, the hospital portion is expected to reach \$3,925,000, an increase of 10%, with the payment for professional services thereby decreasing proportionately somewhat to about 24% of the total of prepaid funds.

I would, of course, hesitate to say that this situation reflects public demand for medically unwarranted use

of the contracts as written and intended; uneconomic organization of personnel and facilities which furnish health care, lack of prepayment programs which include a full range of needed medical services so that those which are medically appropriate are used, or lack of proper controls to guard against unjustified inflation of costs or utilization.

Francis R. Smith, Insurance Commissioner of Pennsylvania, issued a statement of adjudication several weeks ago in the matter of recent filings for rate increase approvals by Pennsylvania Blue Cross Plans. It is the most significant public statement made by a state official in many years. While I recognize he is speaking of another area I think some of the salient points concern all who are interested in the operation and expansion of voluntary, non-profit prepayment, particularly so since the document has attracted the attention of many other State Insurance Departments, including our own, and he has refused to consider future requests for increased rates until some corrective action has been taken.

I quote various excerpts from Commissioner Smith's statement:

"The value of Blue Cross Plans is directly dependent upon the ability of such associations to provide hospital care to the whole community at fair and reasonable costs which the members of the community can afford to pay. It is incumbent upon me as Insurance Commissioner, and all interested members of the community, including hospitals and physicians, to take every reasonable action to lessen the financial burden now borne by citizens in paying the costs of hospital care."

"The need of Blue Cross plans for higher rates is directly caused by the increasing costs of hospital services and the increasing utilization of such services by Blue Cross subscribers."

"The testimony at the hearings showed that hospital administrators have no expectation that hospital costs will level off in the near future. If present attitudes regarding hospital care remain unchanged, if present methods of hospital administration are continued, if present practices in the admission to hospitals of subscriber patients are not corrected, the Blue Cross Plans will be applying year after year for additional rate increases."

"The steadily mounting costs of hospital care are placing the Blue Cross Plans in no less than an emergency condition."

"It should be emphasized that every unnecessary day of hospital occupancy forces Blue Cross subscriber-rates upward." (In the case of our Plan, if each stay could be reduced one day we could save \$600,000 each year.)

"I do not believe that everything has been done to bring about the most efficient and economical management of our hospitals. In fact, I believe very little has been done. I do not believe that everything has been done by hospital administrators, by the Blue Cross organizations, and by the medical profession to eliminate unnecessary admissions and to reduce protracted hospital stays. In fact I believe, with few exceptions, very little has been done. I do believe, however, unless action is taken immediately in both of the above regards, the whole scheme of prepaid medical care through the Blue Cross system will be irreparably injured at the expense of millions of citizens resulting in severe personal and financial hardship and suffering."

"A fact which we all must recognize is that wasteful

and unnecessary use of Blue Cross benefits forces Blue Cross rates upward. Throughout these hearings few, if any witnesses denied that abuses exist in the utilization of Blue Cross benefits. The only question upon which there was disagreement is the extent of the abuse. It is not necessary for the purpose of these adjudications to determine the precise extent of abuse; the fact that it exists justifies remedial action. One physician testified in the Philadelphia Blue Cross hearings that he had been approached many times by patients who desired unnecessary hospitalization. He stated in his testimony that if the staffs of hospitals were really backed by the strength of the county medical society and the Board of Censors they could do much to reduce the abuse of unnecessary hospitalization."

"Another physician also testified that hospital management presses physicians to keep hospital beds filled."

"A hospital Superintendent in the same hearing testified that it would appear that there is overutilization of hospital services as indicated by the variance in the average length of stays in different hospitals for the same illnesses. This same witness indicated that in certain hospitals Blue Cross patients are hospitalized for longer periods than are non-Blue Cross patients."

"No qualified witnesses appearing before the Commissioner in the Pittsburgh hearings denied that abuses in the use of Blue Cross benefits exist."

"One Public Health expert, who was himself a physician, while not denying that abuses in utilization of hospital services existed, testified that detailed studies were needed to establish standards to measure such abuses. This witness hastened to testify, however, that corrective action should not be delayed until such a study was made."

"Testimony submitted in these hearings established beyond any doubt that unnecessary utilization of hospital service can be substantially reduced by proper action and cooperation of all interested parties, including the Blue Cross Plans, their subscribers, doctors, and hospital administrators. Any suggestion that we can't do anything about this because we don't know to what extent the abuses exist should be summarily rejected."

"Testimony admitted into the record of the hearings shows conclusively that hospital administrators and their medical staffs can substantially reduce the abuse of hospital care."

Commissioner Smith concluded: "I do not intend, at this juncture, to involve this discussion in a technical commentary on medical ethics. It should be plain, however, that if, as is implicit in Dr. Haddon's charges, doctors are admitting Blue Cross subscribers to hospitals where such hospital care is unnecessary simply because the hospital bill will be paid by Blue Cross and the doctor is more likely to obtain his fee, grounds certainly exist for disciplinary action. Such conduct on the part of a doctor renders him a collaborator with a private party in the violation of his Blue Cross contract. The record shows that the Philadelphia County Medical Society did little more than pass resolutions on the subject. There is no evidence in the records that the county medical societies in the other counties served by the Blue Cross Plans involved in this hearing did as much. In fact the record in the Western Pennsylvania hearings show that the county medical societies generally have taken no action in this matter. In reply to my questions, Mr. Calder C. Murlott, of the Medical Society of the State of Pennsylvania, stated that the County Medical Society of Allegheny County, to his knowledge, had done nothing about the abuses in hospital utilization growing out of improper admissions by doctors. With respect to state and county medical societies generally, Mr. Murlott

stated that the state society has made recommendations but that "The county societies do not pick up the ball. The state society is in no position to coerce the county societies. We must simply make recommendations."

"There can be no question that much can be accomplished by doctors through their professional societies towards eliminating abuses in the use of hospital care which is causing Blue Cross rates to steadily rise. Hospital admissions are generally controlled by doctors, and the length of stay of each patient is controlled by his doctor. The fact that doctors can do much to lessen abuses was attested to by one physician testifying at the Philadelphia hearings. He said, 'I think that many of the problems that have been complained of here, and abuses, can be controlled, if the County Medical Society comes out against these abuses'."

I am the first to recognize the variegated role that Blue Cross and Blue Shield, as Plans, must play in resolving this situation. Voluntary prepayment has won for itself all of the advantages and responsibilities of being in office — now the question is, how well can we serve the needs of the people — and that means doing something about the remaining two-thirds of the nation's medical bill remaining virtually untouched by any program. This, we are working on at top speed, but this must be said —

If Blue Cross and Blue Shield is to embark upon any significant extension of benefits without artificial monetary controls so economically severe upon the user as to render the program itself practically impotent, we must have, in advance, the understanding and cooperation of everyone involved in the provision of health care, but especially the understanding of the medical profession, the hospitals, hospital administrators, and the public. To start such a program and then attempt to get the necessary understanding and cooperation would be disastrous. If prepayment is to be extended beyond the hospitalized case, the financing agency must have some idea how, where, by whom and under what conditions, the care is to be rendered and what the cost is to be. There is little real evidence, either tangible or in the general attitude of all concerned, that more, better or additional benefits will decrease the use and cost of present benefits or not themselves be subjected to runaway provision. If such is the case, it would be suicidal for already financially hard pressed plans to venture into these unknowns. There is no reason to believe that if a person is unable to drive a small car that giving him a larger one will do any more than increase the damage if a crash occurs.

Non-profit, voluntary prepayment is at a crucial stage. The need for health care will always be with us; those who provide it will remain, as will the need for paying them. Prepayment, *per se* will in all probability not be supplanted. The basic issue is how — what form and under whose control.

Present alternatives are Blue Cross and Blue Shield: group practice; closed panels, and finally government — either administering a compulsory insurance pro-

gram or straightout state medicine with salaried physicians.

The issue is not yet settled. Dr. Aimes C. McGuinness, Special Assistant to the Secretary for Health and Medical Affairs, U. S. Department of Health Education and Welfare, had this to say less than three weeks ago in Roanoke at the Carolinas-Virginias Hospital Conference in speaking on the future role of the Federal Government in providing and financing health care:

"In all honesty, I do not see how one can speculate on the future role of the Federal Government without first coming up with an estimate of what is going to be the future role of the voluntary agencies, industry, the suppliers of health care, and government at community, county, and State levels. To the extent that these sources cannot meet the health needs of the country, we can be sure that the consumers of medical care will make demands on the Federal Government to fill in the gap."

Only by an interlocking partnership of all the providers of health care and the community's non-profit prepayment agencies, working together as efficiently and effectively as possible in the public interest, and with the understanding of the public as to the economy and effectiveness with which its community health services are provided as well as their underlying economics, can gaps be filled thereby forestalling public demands for socialized systems.

A properly designed system of voluntary prepayment with any chance for survival can be devised only out of a deep understanding of medical care. Physicians must assume leadership today in fashioning the voluntary prepayment to come and accept much greater responsibility for its control. Not to do so is to relinquish the controlling voice in shaping the future of American medicine.

May I remind you that this country is one of the very few remaining in the entire world not under governmental control.

During the last two decades the proportion of the American population admitted to hospitals has more than doubled, Health Information Foundation reports. But the average length of stay per person has declined by almost half—from 41.1 days per person in 1935 to 22.4 days in 1956.

Utilization of general hospitals has increased more sharply recently than use of mental and tuberculosis hospitals, according to Health Information Foundation. Even so, the country's psychiatric hospitals still account for more than half of all patient-days.

Men require more hospital treatment than women, Health Information Foundation states, even though women's admission rates are much higher during the childbearing years.

Rural residents are admitted to hospitals more often than urban residents, according to Health Information Foundation. But city dwellers, once admitted to hospitals, generally require a longer stay.

Finally, Dr. Roberts warned that the apparently perfect environment does not always breed perfect health. Neurosis in new housing estates and towns is more common than in the older, less satisfactory

housing conditions, and it appears that some people become unhappy in spite of every effort to help them. Similarly, it appears true that every stage in reducing mortality is likely to bring its own fresh difficulties. This point of view was well expressed by a correspondent in the *Times*, who dared to question whether the results of eliminating bronchitis, cancer and arterial disease would be as desirable a might appear at first sight. He pointed out that other degenerative diseases of senescence would appear and that there would eventually be many more and even older people needing hospitalization. Indeed, the day might dawn when a substantial part of the population would consist of sprightly if austere and abstemious septuagenarians mainly occupied in looking after innumerable bedridden centenarians. Together, they would spend the evening of their days before their smokeless-fuel fires denying themselves the solace of tobacco, afraid to have a drink lest it damage the liver and anxiously scrutinizing every mouthful of food lest it contain a morsel of fat that might damage the arteries. He thought this was a poor way of spending an evening.

John Lister in *The New England Jour. of Med.*
258:1304

Editorials

BLUE CROSS AND BLUE SHIELD NEED MEDICAL POLICING

One of the great difficulties encountered by these agencies, which were sponsored, nursed, and supported financially by the South Carolina Medical Association, has been the persistent abuse of the regulations concerning the type of coverage which the Plans offer.

A not-inconsiderable element of our members has consistently ignored the fact that the Plans stand or fall by the support of the physicians of the state, and that careless, unwarranted, and actually fraudulent use of the provisions of the policies has resulted in a dangerous threat to the continuation of their activities.

This sort of statement has been made many times and in many places, but the hardened sinners among us do not see the light, being concerned apparently only with what they and their over-demanding patients can get out of the funds, without thought of the basic purposes of the Plans as a shield against socialized medicine and a benefit to both physician and patient. This crying in the wilderness of conscience has not had sufficient answer to encourage its continuation.

Medical organizations have had to clean house before now, with some spectacular success, and the time seems right for the conscientious to leap on the conscienceless, and to apply pressure of a sort that really hurts. To effect such a move, county societies and hospitals would have to establish committee for review of the charts of all patients admitted under the provisions of the Plans, and would have to uphold disciplinary action. Such a move would be sufficiently drastic to make it painful enough to put, if not the fear of God, at least the fear of the hand of honest medicine into the minds of the transgressors.

ARE YOUR MEDICAL CREDENTIALS SAFE?

The familiar plight of the foreign physicians

who by reason of catastrophe, has lost his medical credentials, and cannot establish his right to practice medicine in this country brings to mind the fact that someday many of us might find ourselves in the same position as a result of war or other major disturbance.

To reduce the risk of loss of valuable medical diplomas and certificates, The World Medical Association has established a Central Repository in which copies of such papers can be placed, and from which they can be obtained on request. The cost is not large as compared with other insurance. Information can be had from the World Medical Association—Columbus Circle, New York 19, N. Y.

ON BRAND NAMES

An editorial on Brand Name Drugs by Dr. Henry Davidson, editor of *The Journal of the Medical Society of New Jersey*, has been reprinted in several other journals and deserves reading, marking, and learning. Inward digestion informs us that the writer believes that the well recognized efforts and costs of reputable manufacturers in producing a reliable product justify the reward of acceptance of the name which the maker adopts and specification of it in prescribing.

Surely no one can object to this thought, but there are other qualifications which might be considered. If the purpose of the brand name is to give new repute to an already reputable firm, or to a budding competitor, why not use the name of the drug (if it is not entirely too polysyllabic) and the name of the firm e.g. Boswell's tetracycline, rather than Neoantibioticine or some such addition to the existing confusion. The physician knows his pharmaceutical companies fairly well, and a familiar and respected name will be more acceptable to him than some new monstrosity of a term hatched in the promotion man's brain.

The use of brand names in prescription writing differs from their use in writing of scientific papers, for the prescription need be

understood only by the local pharmacist, whereas the paper may be read by many to whom the names are not intelligible. It would seem fair to all to explain at least once in the course of a paper that the brand name means such and such an accepted drug made by such and such a pharmaceutical company. Then everybody should be happy.

The difficulty of understanding such names was recently emphasized during an attempt to read an English text in which the names of drugs were those in the British Pharmacopeia, with a number of proprietaries to boot. Perhaps there is a great field here for the World Health Organization to bring about some universal nomenclature such as Latin once afforded in the scientific world.

STATE BOARD OF MEDICAL
EXAMINERS

In this issue is to be found a report of this Board in which recent activities are described. Among them are certain reasonable relaxations of what were heretofore rather stringent regulations concerning foreign physicians. The status of these physicians has been generally an unhappy one, and without prejudice to the rights and privileges of our own graduates, the Board has made what seems to be a wise provision for better opportunity for our foreign doctors.

The Board has also engaged in disciplinary action in violations of the Medical Practice Act. Four licenses have been revoked, one was suspended, and two physicians were warned against further illegal activities.

The Board performs a very important service to the profession and to the public. It is to be commended for its vigilance and its decisions.

SCHOOL HEALTH COMMITTEE
A SUPPLEMENTAL REPORT

On March 12, 1958, a statewide committee of school health personnel, Health Department personnel, and invited representatives from the state Board of Education and state P.T.A. met at the State Board of Health office building. The purpose of this statewide meeting was to urge local county medical societies to have working committees in each individual county, and it was hoped that representatives from each local medical society

would be present. However, the attendance was rather less than anticipated. Those representatives of the medical societies who did attend appeared to be interested in the problems of school health. It was brought out during discussion that the larger cities with more heavily populated areas could probably carry out the objectives as listed in our original school health report, but it would be difficult or quite impractical in the sparsely populated areas to have such a school health program. At the present time, in these less populated areas when a school health program does develop and operate, it is primarily a function of the local health officer and his department. Under such circumstances, it would seem inadvisable for counties with inadequate medical and school health personnel to discontinue these useful programs that have been started in past years as an effort to improve or develop local school health programs. On the other hand, the recommended program as outlined in our first school health report would seem to more nearly approach the needs of the more urban areas, and also eliminate the practice of the Health Department units performing work which ideally should be performed by private physicians.

The Chairman of the School Health Committee has been requested by Dr. Brown of the State Board of Education to arrange for a symposium on "Athletics and Athletic Injuries" for the state High School Coaches Association, which will be held in Columbia August 8, 1958. A round table symposium has been arranged as requested. This symposium will be made up of Dr. Frank H. Stelling, orthopedist, Dr. Harry W. Mims, physical medicine specialist, and the Chairman of the School Health Committee, pediatrician. It is hoped that this discussion will be a worthwhile project of our state School Health Committee. Officials of the High School Coaches Association are very much interested in such a program being initiated and possibly expanded in future years. Such a program could be integrated with the statewide meeting of high school coaches which is held in Columbia each summer.

Respectfully submitted,
Henry W. Moore, M. D., Chairman,
School Health Committee

The following persons represented State P.T.A. at the Meeting of the School Health Committee, of the Medical Association.

- | | |
|-------------------------|-----------------------|
| Mrs. James H. Gressette | Mrs. Edwin Scott, Jr. |
| Orangeburg | Columbia |
| Mrs. Howard McClain | Mrs. R. S. Bollinger |
| Columbia | Columbia |
- Medical Representatives:
- | | |
|---|-----------------|
| Henry Moore, M. D. | ----- Columbia |
| Chairman, School Health Committee of S.C.M.A. | |
| Hilla Sheriff, M. D. | ----- Columbia |
| Member School Health Committee | |
| W. E. Baldwin, M. D. | ----- Abbeville |
| County Health Officer | |

A. P. Dickson, M. D. -----	Due West
Abbeville Medical Society	
3 members -----	Anderson
Anderson Medical Society	
Leon Banov, M. D. and others -----	Charleston
County Health Officer	
J. B. Floyd, M. D. -----	Fairfield
County Health Officer	
Sarah T. Morrow, M. D. -----	Chester
County Health Officer	
Eugene Yeargin, M. D. -----	Greenville
County Medical Society	
J. C. Harris, M. D. -----	Lancaster
County Medical Society	
R. J. Outlaw, M. D. -----	Saluda
County Medical Society	
T. K. Fairey, M. D. -----	Saluda
County Health Officer	
Sam Elmore, M. D. -----	Spartanburg
County Medical Society	

STATE BOARD OF MEDICAL EXAMINERS

At the annual meeting of the State Board of Medical Examiners of South Carolina, held in Columbia on June 24, 25, 1958, the following officers were elected for the coming year:

Chairman ----- G. R. Wilkinson, M. D., Greenville
Vice-Chairman ----- W. R. Tuten, M. D., Fairfax
Secretary-Treasurer ----- H. E. Jervey, Jr., M. D., Columbia
Executive Secretary ----- N. B. Heyward, Columbia

Several policy changes regarding foreign physicians were passed and have been put into effect.

(1) The Board will consider for internship and residency training in accredited hospitals those foreign physicians who are citizens of one of the countries of our English speaking allies, and are graduates of a qualified medical school located in that country, who have made a declaration of intent to become citizens of the USA and have successfully passed the Educational Council for Foreign Medical Graduates screening examination. These physicians will be considered on an individual basis and those found acceptable will be issued temporary permits on a yearly basis.

(2) Physicians holding foreign diplomas who are board certified or board eligible in their specialty and who have received their specialty training in the USA will be considered on an individual basis to take the written state board examination. Upon successfully passing the examination a permanent license will be issued to those who are full citizens. Temporary permits will be issued on a yearly basis to those who have not received their final citizenship papers. Full citizenship is a strict requirement for a permanent license.

(3) The Medical College of South Carolina is granted the privilege of accepting for post-graduate

training, subject to the approval of the State Board, any physician, whether citizen or not. These physicians will be issued temporary permits, only. It is understood that the facilities of the Educational Council for Foreign Medical Graduates will probably be used for screening these applicants.

The above changes have been arrived at after much study and discussion over a period of several years. The Board feels that South Carolina must assume its share of the responsibility toward foreign physicians; not only for the humanitarian aspects of medicine, but for the benefits that will be derived from them. We can no longer maintain a provincial outlook. With the influx of a few foreign physicians into our hospitals and the Medical College for training purposes, medical influence of the college and the state will be spread to parts of the world where today none exists. Unless these physicians are able to study in our state they will never have any first hand knowledge of the progressive medical practice that exists here and the high class citizens that we possess. It is also felt that these physicians will bring in new ideas and methods which will undoubtedly stimulate our native sons to greater efforts and achievement.

It is not felt that within the confines of the new policies that there will be a large number of applicants. However, those who do fulfill the requirements will be of the highest caliber and most desirable physicians. With these changes there is to be no lowering of standards. The protection of the people of South Carolina and the maintenance of only the highest type medical care will be the primary concern of the Board. This action is to broaden the scope of medicine in South Carolina, not to lower the level.

In conjunction with the regular meeting, hearings were conducted on violations of the Medical Practice Act of South Carolina. The licenses of four physicians were revoked, another was suspended and two other physicians were given warnings.

The Federal Narcotic Agent who was present at the hearings requested that the Board urge all physicians to report to the Bureau of Narcotics any known or suspected violators of the Federal Narcotic Act. He pointed out that this information would be treated as confidential and would in no way necessarily implicate the physician who did the reporting. He was especially interested in knowing of transient drug addicts. These individuals frequently commit crimes and if their whereabouts is known many crimes could be solved quite readily. The Board feels that this is a responsibility which all doctors should willingly accept for the protection of themselves and the citizens of the state.

STATEMENT OF THE BOARD OF TRUSTEES OF THE AMERICAN HOSPITAL ASSOCIATION

I. The American Hospital Association is convinced

that retired aged persons face a pressing problem in financing their hospital care.

2. It believes that federal legislation will be necessary to solve the problem satisfactorily. It has, however, serious misgivings with respect to the use of compulsory health insurance for financing hospital care even for the retired aged.

3. It believes that all possible solutions must be vigorously explored, including methods by which the dangers inherent in the social security approach can be avoided.

4. It believes that the use of social security to provide the mechanism to assist in the solution of the problem of financing the hospital needs of the retired aged may be necessary ultimately. However, it believes that every realistic effort should first be made to meet these needs promptly through other mechanisms utilizing existing systems of voluntary prepayment.

This is the formal position of the AHA at this time. Now the question comes down to where do we go from here?

TRUSTEE 2:12

NEWS

MEDICAL COLLEGE OF VIRGINIA HONORS DR. W. R. WALLACE

On June 2 at a banquet in the John Marshall Hotel in Richmond, Virginia, Dr. W. R. Wallace and eleven other members of his graduating class of the Medical College of Virginia, were awarded their fifty year pins.

According to the *Times Dispatch*, there were 350 guests present at the occasion.

Dr. Wallace, practicing in Chester since 1909, received his AB degree from Presbyterian College, Clinton, in 1903. He served as principal of Ellenton High School in Aiken County for two years and in 1905 entered the Medical College of Virginia where he completed the four years course in three years. The doctor was graduated in 1908 and was appointed as intern in Memorial Hospital, Richmond, Va., as a member of the adjunct faculty in the Department of Physiology.

From Memorial Hospital, Dr. Wallace transferred to Roper Hospital of Charleston and served during 1908-1909. During a part of this service he was Chief of Staff of the Hospital.

Locating in Chester in June of 1909, Dr. Wallace was associated for several years with the late Dr. Harvey E. McConnell, whose practice at that time was the largest in Chester. Following Dr. McConnell's death, his associate continued on in the same offices.

In 1915 in association with Dr. McConnell, Dr. Abell and several others, Dr. Wallace helped to organize the Chester Sanatorium which they operated for a number of years. The Sanatorium group also operated Pryor Hospital for approximately 30 years

before the construction of the new Chester County Hospital.

During his fifty years of medical service, the good doctor has taken an active interest in many activities, including church, civic and public organizations.

Recently at the meeting of the South Carolina Medical Association at Myrtle Beach on May 14, Dr. Wallace was presented a leather-bound citation in appreciation of his services as president during 1944-45 of the Association.

Again on May 23, he was awarded an embossed volume of poems "Golden Leaves" in recognition of 36 years of unselfish service in the interest of public health.

In addition to the above activities, this gentleman has served as president with the Tri-State Medical Association, past-President of Chester Rotary Club and is a trustee of Presbyterian College, Clinton.

When interviewed by a News Reporter this week, Dr. W. R. says that the "first fifty years are said to be the hardest, but I hope the next fifty will be just as satisfactory and pleasant as the first."

Chester News

Lloyd E. Varner, M. D., announces the opening of his office at 201 Cherry Street, North Charleston, for the practice of General Medicine.

Sam G. Lowe, Jr., M. D. announces the association of W. B. Ardrey, III, M. D. Practice limited to pediatrics at 237 S. Charlotte Avenue, Rock Hill.

Jefferson M. Flowers, Jr., M. D., announces the opening of his office for the general practice of medicine at 4725 Rivers Avenue, North Charleston.

RUBY GETS NEW DOCTOR

Dr. W. W. Chiles, a native of Independence, Mo., has moved to Ruby and started the practice of medicine. He will have his offices in the Ruby Clinic.

He is a graduate of the University of Arkansas in the class of 1927.

Dr. Russell Ramsey Mellette, a native of Orangeburg, has assumed his duties as director of The Charleston County Mental Health Clinic.

He succeeds Dr. Joseph H. Marshall, associate professor of psychiatry at the Hospital, Medical College of South Carolina. Dr. Marshall has resumed a full teaching schedule there.

Dr. Mellette was graduated in 1946 from Clemson College and from the Medical College of South Carolina in 1950. After an internship at Wayne County General Hospital at Eloise, Mich. he became director of Edgewood Sanitarium at Orangeburg.

He served in the Navy as a psychiatrist in 1953-55 and after that was with the Medical College here and was part-time psychiatrist with the Mental Health Clinic. Dr. Mellette joined the staff in July, 1956, of

the Neuro-Psychiatric Institute of University Hospital, Ann Arbor, Mich. He received training in child psychiatry there.

RESOLUTION
PASSED BY THE HOUSE OF
DELEGATES,

AMERICAN MEDICAL ASSOCIATION

Introduced by Dr. Samuel J. McLendon
Delegate, California Medical Association

Subject: Voluntary Health Agencies

WHEREAS, the objectives of the principal Voluntary Health Agencies are laudable; and
WHEREAS, these agencies have a distinguished record of contributions to the health and medical care of the American people; and
WHEREAS, the House of Delegates in December 1957 expressed commendation of such agencies and adopted "Suggested Guides to Relationships Between Medical Societies and Voluntary Health Agencies"; and

WHEREAS, it is recognized that the continued effectiveness of these organizations in the fields of public education, professional education and research is dependent upon the retention of their independence and identity; now therefore be it

RESOLVED: That the House of Delegates reiterates its commendation and approval of the principal Voluntary Health Agencies; and be it

FURTHER RESOLVED: That it is the firm belief of the American Medical Association that these agencies should be free to conduct their own campaigns of fund raising and public education and to direct programs of research in these particular spheres of interest; and be it

FURTHER RESOLVED: That the House of Delegates respectfully request that the American Medical Research Foundation take no action which would endanger the constructive activities of the Voluntary Health Agencies; and be it

FURTHER RESOLVED: That the Board of Trustees continue actively its study of these perplexing problems looking forward to their ultimate solution.

DEATHS

DR. H. H. WYMAN, II

On July 30, Dr. Harry Hastings Wyman, II, 83, practicing physician in Aiken County for 48 years until his retirement in 1950, died in Rock Hill following a long period of declining health.

Born in the old Beaufort District of South Carolina, Dr. Wyman was a son of the late Dr. Harry Hastings Wyman and Martha Davis Wyman. At an early age he moved with his family to Aiken.

A graduate of Davidson College and the Medical College of S. C., the latter in 1897, he followed his

father and grandfather, who finished the medical college in 1875 and 1881, respectively.

His grandfather, Dr. Joel W. Wyman, was a member of the first class graduated by the Medical College.

Dr. Wyman first practiced in Ninety Six and in Georgetown until he came to Aiken in 1902. In the early days of his practice he was associated with his father as Dr. H. H. Wyman & Son. He was an early head of the old Aiken Tuberculosis Sanitarium, a founding physician of the Aiken County Hospital and for many years president of the S. C. Board of Medical Examiners. His practice in Aiken was extensive and he was held in the highest esteem by both his patients and his fellow practitioners.

DR. J. W. CHAPMAN

Dr. Jefferson Watson Chapman, 54, practicing physician in Walterboro, died July 7 after an illness of several months.

Dr. Chapman was born in Columbia, son of Mrs. T. J. Chapman of Columbia and the late Thomas Jefferson Chapman of Edgefield County.

Dr. Chapman graduated from Presbyterian College with an A.B. degree in 1924. He graduated from the Medical College of South Carolina in 1928 and took post graduate work in Belgium. He was a surgeon in charge at the Presbyterian hospital in Bulape, Belgian College from 1929 to 1939. He served as radiologist at Esdorn Memorial Hospital from 1939-45 and had been engaged in private practice since 1940.

Dr. Chapman was a member of the advisory board of Selective Service during World War II. He was a former trustee of Walterboro public schools and of Presbyterian College.

He was part owner of the Chapman Clinic and was elder in the Presbyterian church since 1929.

He was a member of the Colleton County Medical Society, the Coastal Medical Society, S. C. Medical Medical Association, Tri-State Medical Association, Southern Medical Association and the Association of American Physicians and Surgeons.

King Leopold of Belgium presented him with the Order of the Lion in 1939.

He was a member of the Lions Club, Phi Chi Medical Fraternity and Boy Scouts of America.

From 1924-34 he was a member of the Officers Reserve Corps.

Dr. Chapman served as councilor from District I of the South Carolina Medical Association for a number of years.

DR. H. T. HALL

Dr. Huger Tudor Hall, 50, Aiken physician, died July 25, 1958 after a long illness.

A lifelong resident of Aiken, Dr. Hall was a son of the late Dr. Huger T. Hall and Mrs. Anna Aldrich Hall. He attended Aiken elementary schools,

Lawrenceville School for Boys and was graduated from Washington and Lee University and the Medical College of South Carolina.

He had practiced medicine in Aiken since 1935.

DR. L. L. RICHARDSON

Dr. L. L. Richardson, 91-year-old physician and mayor of Simpsonville, died in a Greenville hospital, August 9.

Dr. Richardson, long prominent in medical circles was in his 42nd year as mayor of his Greenville County town.

He remained active until recent weeks and continued to do a limited amount of medical practice. He had been in failing health several months.

ANNOUNCEMENTS

AMERICAN CANCER SOCIETY SCIENTIFIC SESSION PROGRAM

Biltmore Hotel, New York
October 20-21, 1958

SYMPOSIUM ON CANCER OF THE COLON AND RECTUM

In addition to the presentation of papers, the speakers will participate in a panel discussion as a part of each session. All sessions are open to doctors and medical students.

Inquiries concerning this program should be addressed to:

Director, Professional Education
American Cancer Society, Inc.,
521 West 57th Street,
New York 19, New York

THE SOUTH CAROLINA CHAPTER OF THE AMERICAN ACADEMY OF GENERAL PRACTICE AND THE COLUMBIA MEDICAL SOCIETY ANNOUNCE

A POST-GRADUATE SEMINAR WITH ROUND-TABLE DISCUSSIONS

THE COLUMBIA HOTEL

Columbia, South Carolina
Wednesday, September 17, 1958

MORNING SESSION

Moderator: Wm. S. Hall, M. D.

10:00 A. M.—*Management of Pediatric Emergencies*

Carl C. Fischer, M. D., Philadelphia

10:30 A. M.—*Management of Common Dermatologic Conditions*

Carroll F. Burgoon, Jr., M. D., Philadelphia

11:15 A. M.—*ENT Problems in General Practice*

O. E. Van Alyea, M. D., Chicago

12:00—*Luncheon for physicians and wives—Empire Room*

Chairman—Homer M. Eargle, M. D., President
South Carolina Chapter of the American Academy of
General Practice, Orangeburg, South Carolina
Speaker—"The Generalist and the Specialist"

John S. DeTar, M. D., Past-President
American Academy of General Practice, Milan, Mich.

AFTERNOON

Round-Table Discussions

MANAGEMENT OF PEDIATRIC EMERGENCIES

Carl C. Fischer, M. D.

2:00 P. M., 3:00 P. M., and 4:15 P. M.

Moderator: J. R. Paul, M. D., Charleston

MANAGEMENT OF COMMON DERMATOLOGIC CONDITIONS

2:00 P. M., 3:00 P. M., and 4:15 P. M.

Moderator: John Van De Erve, Jr., M. D., Charleston

ENT PROBLEMS IN GENERAL PRACTICE

O. E. Van Alyea, M. D.

2:00 P. M., 3:00 P. M. and 4:15 P. M.

Moderator: Richard W. Hancikel, Jr., M. D.,
Charleston

5:30-6:30 P. M.—*Reception—Empire Room*

Wives of physicians are welcome and encouraged to attend.

No fee is required for attendance at scientific sessions, luncheon or reception.

Six hours of Category I Study Credit will be awarded by the American Academy of General Practice for attendance at this symposium.

HUMAN CONVALESCENT SERA NEEDED

The Laboratory Branch of the Communicable Disease Center is in need of human convalescent sera containing antibodies against the following diseases. Minimum acceptable titers are listed after the diseases.

Rickettsialpox CF — 1:64

R M S F CF — 1:64

O Fever CF — 1:64

Typhus CF — 1:64

Influenza CF Soluble Antigen — 1:128

Psittacosis CF — 1:64

Polio CF — 1:32; Neut. In. 1:128

Mumps CF Soluble — 1:64; Viral — 1:64

Leptospirosis CF — 1:128; Agg. 1:1000

Histoplasmosis CF — 1:128

Blastomycosis CF — 1:64

Coccidioidomycosis CF — 1:128

WEE CF — 1:32; Neut. In. 1000+

EEE CF — 1:32; Neut. In. 1000+

St. L. E CF — 1:32; Neut. In. 1000+

Herpes CF — 1:32

Coxsackie — Neut. 1:64

ECHO — Neut. 1:64

LCM CF — 1:32; Neut. In. 1000+
Adenovirus CF — 1:32; Neut. In. 1:64
Brucella aggl. — 1:320
Echinococcosis CF — 1:16
Tularemia Aggl. — 1:320
Trichinosis

We supply a complete bleeding kit with full instructions, and pay charges for shipping. We are permitted to pay \$5.00 to the person who draws the blood and five cents per ml of whole blood to the donor. We like to get quantities of 500 ml if feasible. The blood should be allowed to clot and the serum separated before shipment to us. If proper precautions are taken, no refrigeration is necessary. Payment is made by Government voucher.

John F. Winn, D.V.M., M.P.H.
Chief, Diagnostic Reagents Section
Laboratory Branch
Communicable Disease Center
P. O. Box 185
Chamblee, Georgia

TENNESSEE VALLEY MEDICAL
ASSEMBLY
(SPONSORED BY THE CHATTANOOGA
AND HAMILTON COUNTY MEDICAL
SOCIETY)
READ HOUSE, CHATTANOOGA,
TENNESSEE
MONDAY, SEPTEMBER 29, AND
TUESDAY, SEPTEMBER 30, 1958

Nineteen well-known speakers will present the program.

Heavy demand for hotel accommodations makes it imperative that physicians who plan to attend the Assembly write without delay for reservations to: Chattanooga Convention & Visitors Bureau, 819 Broad St., Chattanooga, Tennessee.

Registration fee is \$15, enclose with reservation request and check payable to Tennessee Valley Medical Assembly. Early registration is urged and should be sent to: Chattanooga Convention & Visitors Bureau, 819 Broad St., Chattanooga, Tenn.

Program approved for postgraduate study, Category 1, for members of American Academy of General Practice.

On November 12, 13, 14 and 15, 1958 the Second Oklahoma Colloquy on Advances in Medicine will be devoted to Arthritis and Related Disorders.

The program has been developed by the Department of Medicine and the Division of Postgraduate Medical Education of the University of Oklahoma Medical Center and is being sponsored by Geigy Pharmaceuticals, Wyeth Laboratories, the Upjohn Company, Pfizer Laboratories, Schering Corporation and the Oklahoma Chapter, Arthritis and Rheumatism Foundation.

Eleven nationally prominent investigators will participate and present the results of original work and clinical experience.

Registration will be open to all physicians. There will be a registration fee of \$25.00. Members of the Armed Forces, interns and residents may attend without charge. Interns and residents must present a letter from the Chief of Staff of their hospital. Further information may be obtained by writing the Office of Postgraduate Education, University of Oklahoma School of Medicine, 801 Northeast 13th Street, Oklahoma City, Oklahoma.

Football fans everywhere will be interested in the Missouri-Oklahoma game held at Norman, Oklahoma on November 15th, the final day of the meeting. Norman is some 20 miles from the Medical Center where the program is being held.

Irwin H. Brown, M. D.

SOCIETY FOR CLINICAL AND
EXPERIMENTAL HYPNOSIS

The Society for Clinical and Experimental Hypnosis, an International Scientific Society, comprised of physicians, dentists and psychologists engaged in the clinical use of hypnosis, will present an outstanding scientific program in Chicago at the Morrison Hotel, October 29-31, 1958.

Immediately preceding the Annual Meeting of the Society for Clinical and Experimental Hypnosis, the Institute for Research in Hypnosis of the Long Island University Postgraduate School will present its Annual Workshop in Clinical Hypnosis, October 27-29, at the Morrison Hotel.

For a copy of the program and more detailed information, write to the Administrative Secretary, Society for Clinical and Experimental Hypnosis, 750 N. Michigan Avenue, Chicago 11, Illinois.

SOUTHEASTERN SURGICAL CONGRESS
1959 PRIZE SCIENTIFIC PAPER AWARD

The Southeastern Surgical Congress announces its Annual Prize Scientific Paper Award for 1959. The best unpublished contribution on surgery or allied subjects will be awarded \$100.00 and expenses for the author to attend its next Annual meeting in Miami Beach, Florida. The second place winner will receive \$50.00 cash and the third place winner will receive \$25.00 cash.

The contest is open to residents in AMA approved residencies in the state of South Carolina. Three copies of the paper should be sent before December 1, 1958, to the Councilor of the state in which the resident is living. The Councilor's name and address may be obtained by writing to the home office of the Southeastern Surgical Congress at 1032 Hurt Building, Atlanta 3, Georgia.

The winner will present his paper before the Congress Assembly in Miami Beach, March 9-12, 1959.



BLUE CROSS . . . BLUE SHIELD



Policy Regarding Hospital Benefits for X-Ray and Other Laboratory Diagnostic Examinations

Diagnostic hospital admissions *per se* are granted only limited benefits under the Blue Cross contracts. When a subscriber is admitted by his doctor to hospital for treatment of a *bona fide* illness which in his doctor's judgment requires hospital care, benefits are granted for diagnostic tests and procedures including laboratory tests and examination of tissue and x-ray examinations when such tests are related to either the admitting or the final diagnosis. If they are simply a part of a general diagnostic survey or a prophylactic health examination, they are not covered by the contract.

An admitting diagnosis need not be necessarily a firm or true diagnosis. Rather, it may and of necessity, it must be frequently a statement of a presenting symptom of such severity as of itself to warrant hospital treatment.

When patients with chronic illnesses, apprehensions, and suspected diseases which of themselves do not require hospital treatment and which do not preclude examinations and treatment on an out-patient basis, are hospitalized for x-ray and other laboratory examinations, they will receive diagnostic benefits only.

Let's Make It The Doctors' Plan

Dr. Norman A. Welch is chairman of the Blue Shield Commission. In an address before the Blue Shield Professional Relations Conference, he said some things that every physician and everyone connected with management and every other employee of Blue Shield should always bear in mind. He said:

"Professional relations involve relationships between Blue Shield plans and the physicians upon which the plans at present are truly dependent for success." Then he said that the essential foundations for assuring progressive refinement and development in Blue Shield coverage involve the relationships of the plan with its local physicians. The physician must at all times understand the reasons for every projected change in Blue Shield to assure that he understands the basis for the changes. He should be in a position to have the necessary viewpoint of the physician in practice if he is to assist in shaping the course of future developments of Blue Shield.

The whole Blue Shield program is based on the concept that Blue Shield is the doctors' plan of promoting the means of paying the costs of medical

treatment. Since it is the doctors' plan, the doctors must not only understand and accept its philosophy of service, but they must assist in the mechanics of its application.

Our plan in South Carolina gradually slipped away from recognition and application of the necessity of a cordial and mutually understanding relationship between the plan and the doctors. There were several reasons for this. Members of the Board came to feel that the doctors generally were not particularly interested in the plan, except as its schedule of allowances affected the individual physician and his practice. They came to feel that the doctors generally did not understand the basic philosophy of Blue Shield and that they made no distinction in their attitude toward and thinking of Blue Shield and commercial insurance companies. There came about a feeling of frustration in the educational efforts of the plan.

Three years ago, a beginning was made in trying to draw the South Carolina Medical Care Plan and the South Carolina Medical Association closer together. The Board of Directors of the plan requested a change in the by-laws, whereby the president of the State Association and the chairman of Council would be *ex officio* members of the Board. This change was approved. It came at a fortunate time. Dr. William Prioleau was president of the State Association and Dr. Joseph Cain was chairman of Council. They both accepted their duties and obligations of Board membership seriously. This was a good beginning.

Plan management then made a series of tragic blunders. Perhaps, management felt some frustration because of what seemed to be either an antipathy or an animosity on the part of so many doctors towards Blue Shield. Be that as it may, the plan was faced with a financial emergency. Immediate drastic action seemed imperative. Such action was taken without consultation with the doctors and with incomplete or ambiguous explanation of announced changes. The reaction by the doctors was immediate and drastic. The Blue Shield Board and the Council, under the aggressive leadership of Dr. Cain, and management have worked energetically and continuously to undo the damage done by the precipitant action of management. Things seem to be running now on an even keel. Management has learned a lesson, as has the Board. Sustained interest in the workings of the plan has been aroused in the members of Council and in many doctors throughout the state. Relations with the doctors generally seem to be good at this time. A professional relations director has been employed by the

plan. The doctors of the state will be seeing a good deal of this very pleasant and understanding gentleman. Perhaps, the cycle of doctor interest in Blue Shield will run the gamut from indifference, to hostility,

to tolerance, to pride. It will be a great day for South Carolina Blue Shield when there is a general pride of ownership of it among the doctors.

J. Decherd Guess

ONE HUNDRED AND TENTH ANNUAL SESSION OF THE SOUTH CAROLINA MEDICAL ASSOCIATION. HOUSE OF DELEGATES

MYRTLE BEACH, S. C., MAY 13TH AND 14TH, 1958, OCEAN FOREST HOTEL

Dr. D. Lescene Smith, Presiding

(Continued from August Issue)

PRESIDENT SMITH: Now gentlemen, the President took the privilege of appointing another committee. You remember last year there was certain discussion in regard to medical care and the Medical College, in relation to the Medical Association. Great care was taken in the selection of the members of this committee, and we selected one from each district in the State. I will read first what I wrote to the Committee. "This special committee is to study methods of communication between the State Medical Association and the Medical College. This committee was requested to make recommendations to the State Medical Association as to whether a liaison committee is feasible and/or desirable and the type and membership of such a committee".

I mentioned to you that each district was represented. Chairman, Dr. Frank Owens; others, Dr. Henry Robertson, Dr. W. W. Edwards, Dr. Howard Stokes, Dr. A. B. Preacher, Dr. J. A. McQuown, Dr. John Brewer, Dr. C. R. F. Baker, Dr. Charles Hanna. I will ask for a report from Dr. Frank Owens.

DR. OWENS: Your special Committee, appointed to study liaison between the State Medical Association and the Medical College, submit its report as follows: After careful study, your Committee recommends that no Liaison Committee be established between the South Carolina Medical Association and the Medical College of South Carolina at this time.

This report was unanimously adopted at a meeting of the Committee, March 30, 1958.

Frank C. Owens, M. D.

PRESIDENT SMITH: Dr. Owens, will you stay up in front please? I would like to thank you for the work you did. This report will be referred to the Committee on Miscellaneous Business.

Now you are Chairman of the Advisory Committee on Selective Service. Do you have a report to make on that?

DR. OWENS: Last year the Doctor's Draft Act was done away with, but a good many doctors were still available for the draft, because of age, and therefore technically speaking they could be called up at any time under that draft. The policy in our selective service is to not call up any doctors, no matter what age they are. If a quota goes to a county for 50 men say, the board is instructed not to include any doctors or dentists in that number. If there is going to be a call to doctors, the President will issue a special call for the selective service to call doctors under 26 years of age. None was called during the last fiscal year and none is expected to be called, or we have been assured there will be none called, and there are no indications that they are going to call any at any time soon, unless some emergency arises.

PRESIDENT SMITH: Thank you very much Dr. Owens. This last report will be referred to the Committee on Miscellaneous Business.

PRESIDENT SMITH: We have one other special committee on Permanent Home for Medical Association, Dr. Joe Cain, Chairman.

DR. CAIN: Dr. Mayer has the report.

PRESIDENT SMITH: All right, Dr. Mayer.

DR. MAYER: The Committee appointed by the Chairman of Council to study the advisability of the State Association having a permanent home (i.e. Headquarters Building) is still in the process of study. We have exchanged ideas with each other. Dr. Guess has obtained data from Tennessee, Georgia, Mississippi, Virginia and Florida, five southern states that now have homes.

Material furnished by the A.M.A. indicates eighteen states already have homes and a few others are in the planning stage.

We believe the South Carolina Medical Association should start planning now for a future Permanent Headquarters Building.

We believe the membership at large has not yet accepted the idea because the reasons and need for a home have not been adequately presented to them. Before definite plans and recommendations are made, additional information and facts should be presented to the membership.

With this in mind, articles from Drs. Guess and Hanckel were prepared and appeared in the April issue of the *Journal of The South Carolina Medical Association*.

It is recommended that a Study Committee be continued and that the members be further acquainted with the needs for and benefits that will be derived from a Permanent Home so that plans may be made at a proper time.

The members of the Committee are:

Dr. J. Decherd Guess, Greenville
Dr. Richard W. Hanckel, Charleston
Dr. Kenneth G. Lawrence, Florence
Dr. O. B. Mayer, Columbia

PRESIDENT SMITH: Thank you very much sir. That will be referred to the Committee on Miscellaneous Business also.

Mr. Meadors has two reports, I think.

MR. MEADORS: Mr. President, one of these matters consists of a letter received from Dr. M. Kershaw Walsh, Chairman of the Legislative Committee of the South Carolina Psychological Association. Dr. Walsh is a member of the Department of Psychology and Philosophy at the University in Columbia. This letter

was written in consequence of a conversation with me.

Dear Mr. Meadors:

This is in reference to our recent telephone conversation concerning the proposal of the South Carolina Psychological Association to initiate legislation to certify psychologists in this state in accordance with the nation-wide trend.

A general outline of the significant items of this proposed measure is enclosed on a separate sheet.

In view of the fact that psychologists in this state have always worked in close relationship with the members of the medical profession and are mostly employed in state clinics and hospitals, we are sensitive to the interests of your association and desire to cooperate with you fully. We feel that the certification of psychologists will not only protect the public against unauthorized and improper psychological service but also that the establishment of the proposed controls will be in the best interest of the medical profession, which has historically labored to protect the public from exploitation.

It is not our intention to ask for the active support of your organization in the undertakings of our group. We are aware of the fact that you have problems of your own which might well exclude such open espousal. It is requested that you appoint a small committee, preferably centrally located, which would be authorized to meet with our legislative committee and help us to anticipate and smooth out points which are likely to be sources of misunderstanding between the two professions. Your consideration in this matter will be appreciated.

Cordially yours,
M. Kershaw Walsh, Chairman
Legislative Committee
S. C. Psychological Association

PRESIDENT SMITH: Mr. Meadors, this letter will be referred with its enclosure to the Committee on Legislation and Public Relations.

MR. MEADORS: The other matter involves two subjects suggested in a letter from Dr. G. S. T. Peeples, the State Health Officer, and I will simply read the letter without further comment.

Dear Mr. Meadors:

Dr. William S. Hall, Superintendent of the State Hospital, and Dr. W. P. Beckman, Director of Mental Health, have discussed the need of an amendment to Section 32-671 of the 1952 Code of Laws of South Carolina, which has to do with the sexual sterilization of certain inmates of penal and charitable institutions. Before requesting the Legislature to enact such an amendment, it is the desire of these gentlemen and of the Executive Committee of the State Board of Health that the matter be brought to the attention of the House of Delegates for endorsement.

The amendment under consideration would provide not only for the sterilization of patients in institutions who are mentally incapable of protecting themselves from unscrupulous individuals, to which the law is now limited, but would include cases who are seen in psychiatric clinics, and who have been diagnosed by either the out-patient clinics of the State Hospital, or by at least two reputable psychiatrists other than the Superintendent of the State Hospital. In any event, we feel that these cases should be reviewed by the Superintendent of the State Hospital before the presentation of them to the Executive Committee for final action. We do not feel that the public is prepared at this time to condone a law which would extend the power of sterilization to other than mental hospitals. This, of course, is an assumption, and is based upon the feeling that the suspicious public might think that this is an entering wedge to have

promiscuous sterilizations carried out through the general hospitals of the State.

We might add that it seems inconsistent under the present circumstances, where competent psychiatrists are available in the various sections of the State, and where mental health clinics are fairly well distributed throughout the State, that it would still be necessary for a patient to have to be admitted to the State Hospital for a period of ninety days to determine whether or not he needs sexual sterilization. This, to our way of thinking, is quite a waste of bed space, time, and money.

We have no suitable bill drawn up for such an amendment. We merely wanted this adopted in principle; and then we will request your assistance in writing up a proposed amendment, along with the Attorney General, etc.

Another item which we feel should have the endorsement of the House of Delegates is the enclosed Radiation Hygiene Act, S-405. In 1956 the South Carolina Legislature passed an act requiring the State Board of Health, the Highway Department, etc., to present to the 1957 legislative session any bills which they felt would be needed for the proper control of radiation in this State. The enclosed bill is simply a measure designating the State Board of Health as the official agency to deal with the Atomic Energy Commission, and further, to grant it powers to make rules and regulations for the permitting and control of radiation activities within the State. At the present time the Atomic Energy Commission does all of the licensing of reactors, etc., and does an excellent job of control until they are delivered to a State. After that the conduct of the operators and the safety of employees and of the general public becomes the responsibility of some agency within the State. Upon the recommendation of the Southern Regional Education Board, the Governor made a study of this subject, and recommended the State Board of Health as the official agency.

The enclosed bill was passed by the Senate during the 1957 session of the Legislature, and is now in Committee in the House of Representatives. It will automatically die there at the end of this session.

We shall appreciate your taking the steps necessary to have these two items presented to the House of Delegates during the annual meeting, and we shall be glad to appear before the reference committee to answer any questions on these subjects.

Sincerely yours,
G. S. T. Peeples, M. D.,
State Health Officer

PRESIDENT SMITH: This will be referred to the Committee on Public and Industrial Health.

PRESIDENT SMITH: We will now have a report from the State Board of Medical Examiners. Report is read by Dr. Wilkinson.

DR. WILKINSON: As matters now stand we have a comparatively small, compact, uniform State Association, and we are not confronted with things that other states are confronted with. However, as the State grows, we will have no way of keeping up with people we don't know. Now we have some six hundred people practicing elsewhere who have South Carolina licenses. These people might come back here at any time after crime or what not in other states, and we have no way of tracing them. This problem is increasing and I think within the next two or three years we will have to have some registration law. But I believe that this law will have to come up with an amendment to the Practice Act, and will have to be enforced by an act of law rather than by an act of this body. But there is no reason to ask for any act of law on this matter until the doctors of this Association are sold on this proposition and feel

like they want it. The amount of money involved is very small, but there are a lot of people who object to even a very small amount of money each year for registration. But it is mandatory in 39 states now, and it is hardly possible to think we will be able to go along without some sort of arrangement to keep up with everyone who hasn't a license.

PRESIDENT SMITH: Thank you very much Dr. Wilkinson. Your report will be referred to the Committee on Legislation and Public Relations.

PRESIDENT SMITH: Next Committee report, of the Executive Committee of State Board of Health, Dr. Wallace.

DR. WALLACE: No additional report.

PRESIDENT SMITH: Any other committee reports? Dr. Wilson.

DR. WILSON: Council this morning directed that this be called to the attention of the House of Delegates and referred to the proper Reference Committee for recommendations.

It is a digest of a Uniform Hazardous Substances Act. (The Digest is read by Dr. Wilson.) There is attached a copy of a suggested and proposed uniform act, and it is asked that it be referred to the Committee on Legislation.

PRESIDENT SMITH: That will be done.

PRESIDENT SMITH: We have the committees lined up and I will ask Mr. Meadors to read out where they will meet.

MR. MEADORS: The committees and the meeting places are listed on this blackboard but I don't believe you can see it, so I will read them. (The contents of the blackboard are read by Mr. Meadors).

PRESIDENT SMITH: Any other business?

DR. BAXTER: Mr. President, as a delegate from the Georgetown County Medical Society, I have been requested to make the following recommendation.

At a regular meeting of the Georgetown County Medical Society the following resolution was passed by majority vote:

Be it resolved, that the Georgetown County Medical Society present to the next annual meeting of the South Carolina Medical Association a resolution that a standing committee of the State Medical Association be established for the purpose of maintaining liaison with the South Carolina Medical College, and the South Carolina Medical College Hospital.

That the function of this committee will be to maintain proper and harmonious relations between the practitioners of medicine in the State of South Carolina and the community hospitals with which they are concerned, and the Medical College Hospital of South Carolina, Charleston, South Carolina.

O. D. Baxter, President

PRESIDENT SMITH: That will be referred to the Committee on Miscellaneous Business. Any other unfinished business?

DR. PRIOLEAU: Mr. President, I wish to offer a resolution.

WHEREAS the Medical College of South Carolina is increasingly engaging in the practice of medicine at the various economic levels through its associated hospital and faculty members, BE IT RESOLVED that the South Carolina Medical Association propose to the Medical College of South Carolina the establishment of a liaison committee to promote closer co-operation between the Medical College Hospital and its staff and the general medical profession and the community hospitals in the state.

Wm. H. Prioleau

May 13, 1958

PRESIDENT SMITH: Thank you sir. This will be referred to the Committee on Miscellaneous Business. Any other unfinished business? Any new business? Gentlemen, following this meeting we have a meet-

ing, Annual meeting of the Corporation of the South Carolina Medical Care Plan. If it is your pleasure we will take about seven minutes recess and come back. ANNUAL MEETING OF THE SOUTH CAROLINA MEDICAL CARE PLAN.

DR. GEORGE DEAN JOHNSON, PRESIDING.

PRESIDENT JOHNSON: Gentlemen, I think we had better get started. I now declare the Corporation of South Carolina Medical Care Plan in session. The minutes of the last meeting have been circulated in *The Journal* and if I hear no motion to the contrary that we read them, we will dispense with the reading of them. Hearing none I declare the minutes as circulated approved.

The first report will be that of the President. (The report of the President is read by Dr. Johnson).

REPORT OF THE PRESIDENT OF BLUE SHIELD TO THE HOUSE OF DELEGATES

Your Blue Shield Plan has taken important steps this year in following some of the suggestions of the doctors in the state. The first get-together was a group that met in Columbia in July 1957 to air complaints as well as to hear the side of the administration. It was a worthwhile meeting in that the executive director had a chance to hear the more important complaints as well as answer reasonable questions by physicians. Each member of the council was asked to name five doctors in his district to attend. We were glad to have at that meeting Mr. Castalucci, the national executive director. His suggestions and comments were valuable and well received.

The Council was instructed last May to meet with the Blue Shield Directors and report back to the profession in the state. This meeting was held in September in Columbia and was also very valuable not only to Council but also to the directors of Blue Shield. Then each county or district medical society was asked to have a called meeting and in large part this was done. The meeting was for the purpose of explaining the recommendations which Council with Blue Shield had drawn up. All but three societies in the state endorsed the recommendations and the Blue Shield Plan began the implementation of the recommendations. These recommendations have been circulated to every physician in the state in September as well as in April. It is unnecessary to repeat them here.

Again in February Dr. Lesesne Smith asked me as President of Blue Shield to be on the program at a meeting of the officers of the county societies in Columbia. I appreciate the opportunity and I believe a good many present had a much better understanding of the purposes and aims of the Plan. At that meeting one physician suggested that each county or district society have a member on a committee to represent Blue Shield in that area. We think that is an excellent plan and hope to put it into effect. We will continue to work through and with the help of Council. In all these meetings, in all discussions, we have been struck by the fact that most criticism arises from misunderstanding of sometimes the purpose of the plan and more often the details of the operation of the plan. When an explanation is given usually the doctor agrees.

The administration has had its difficulties too. People who work in headquarters are human like you and me and are subject to an honest mistake just as you and I and our office force are. The mistakes are unintentional and embarrassing. The main office was moved to Columbia last August with an almost unbelievably small amount of interruption of operations. Every effort is being made in the office to facilitate payment of claims and especially answer to physicians questions and complaints. We beg you to let us know your complaints and also to be reasonable when an honest error or delay has been made. The

Executive Director has taken one of our most effective salesman off the sales force and put him in the position of physicians' relations. This announcement was made the last of April. He will be calling on you. Please receive him, because he represents the doctors', your, Blue Shield Plan. His name is Bob Thomlin.

I would like to pay tribute to our Board of Directors. Its members work without compensation at considerable sacrifice of time and effort. This is especially true of our lay members who really should not have anything like the interest that you and I as physicians should have. Lesesne Smith and Joe Cain and Council have been very helpful and completely cooperative. Without their help and suggestions our plan would have operated less effectively.

Especially do I thank and publicly praise Mr. Sandow, Mr. Starin, Mr. Diek and other members of their staff for the monumental work they have accomplished. Under Mr. Sandow's able direction order has been brought out of chaos. It would have been infinitely easier to start new from scratch than it has been for them to undo, reorganize, and develop a brand new operation. Your plan now is in a position to be of greater service to the people and to the physicians than ever before. Mr. Sandow is not satisfied or smug by any means but he has a right to feel proud of his staff and we are proud also. We seek the understanding and cooperation of the physicians of our state. Without the wholehearted backing of the medical profession no Blue Shield Plan can achieve its highest purpose. On behalf of the Board of Directors and the staff of the office we urge you to continue your support and allow the plan to fulfill its purpose.

PRESIDENT JOHNSON: We will next hear from the Executive Director, Mr. Sandow. (The report of Mr. Sandow is read and appears in this *Journal*)

PRESIDENT JOHNSON: Thank you, Mr. Sandow, for that thought-provoking talk.

The outcome of the Blue Shield and Blue Cross in this State devolves eventually on you and me as physicians. We can't control all of the illnesses but we can control to some extent some of the admissions and I am sure you will agree with me that in a great many instances our patients might be discharged from the hospitals sooner. How well we conscientiously follow those simple rules, will determine how well Blue Cross and Blue Shield operate in this State.

There is no old business. Is there any new business to come before the delegates?

DR. PRIOLEAU: Mr. President. I have been in Chicago at a Blue Cross and Blue Shield meeting, and I thought it might be worth while to give a few of the thoughts which were particularly emphasized, and about which I think we should try to help.

There is no question about the fact that when Blue Shield started it started to take care of the low income group. Now, Blue Shield, Blue Cross, has to be looked upon as a tremendous social move now. It is going ahead and it is going to have to follow the trends of the times. It has got to take into consideration that the six and seven thousand dollar income group are just as hard put to it to pay their bills as the lower income group, from this standpoint, that they are not going to be able to pay you, and the only way that group is going to be able to pay is the prepayment plan, and we have got to realize that and make our fees in accordance.

Now one thing that has impressed me is the importance of patient participation. It has been shown in too many instances that that is about the only way to control over-use, over-utilization, if you may call it that. I hear the discussion, let the patient pay twenty percent of the first dollar and Blue Shield pay

the last eighty. That cuts down things a great deal. As it is now, the patient says, we don't pay for the first three days, then we will stay three days longer and make up for the three days which Blue Shield doesn't pay for. Now the other factor we have to realize, every doctor can't share in Blue Shield. There are certain fields that can't do it, and the patient should be insured according to what protection they need. Now the average patient doesn't need \$5.00 for opening a boil or something of that nature, and that is tremendously expensive insurance. And of course if there is a lot of that \$5.00 trade, it means that when they do have a baby or something else, the fee has to be proportionately reduced.

One point more. The comparison is often made with commercial insurance, and Blue Shield. Well, it cannot be really compared. Most of us own a little stock in commercial insurance, and we have commercial insurance, and if you belong to this Association you get preferred risk. Now Blue Shield cannot limit itself to good risks, and that is one reason why it cannot be compared with the commercial insurers. The physicians have to take their part in the social movement and help to keep the practice of medicine on a private basis, and the only way they can do that is to take care of the poor risks as well as the good risks.

PRESIDENT JOHNSON: Thank you Dr. Prioleau. Dr. Prioleau was sent by our Blue Shield directors to the National Association meeting. We try to make it a point to send a different doctor every year from the Board, in order that more men will get a better idea of Blue Shield and Blue Cross. And judging by the remarks he has made I would certainly say that his trip has borne fruit.

Any other new business to come up?

According to the laws that set up this organization, nominations for members to the Board are made by the Council, and I will ask Dr. Joe Cain as Chairman of the Council to make those nominations.

DR. CAIN: Mr. President, and members of the corporation, the following have been nominated by Council to fill the places on the Board of Directors for the next three years. As your President just told you, the nominations to this Board of Directors are made by Council, which means that you cannot nominate anyone from the floor. However, if you do not wish to elect any of these nominees you can fail to elect them and additional nominations will be made by Council. The nominees are Dr. A. C. Bozard, Dr. George Dean Johnson, Dr. Charles J. Lemon, Jr., Mr. S. T. Nisbet, Dr. Graham Segars, Mr. Thomas C. Vandiver.

PRESIDENT JOHNSON: Gentlemen, you have heard the nominations. Do you wish to vote individually or collectively?

The motion is made to vote all together and carried.

PRESIDENT JOHNSON: All in favor of the slate as proposed by Dr. Cain please say aye. The motion is carried.

Anything else to come before the meeting? If not the meeting is adjourned.

MAY 14th, 1958

The meeting is called to order by President Smith at nine o'clock, A. M., May 14th, 1958.

PRESIDENT SMITH: Gentlemen, please come to order.

Is there any report from the Credentials Committee?

DR. MAYER: Mr. President, a quorum is present.

PRESIDENT SMITH: Gentlemen, the first order of business is the report of the Reference Committees. As you know these committees were appointed to give full discussion to the various subjects so that it would not have to take hasty action, and there would

be some consideration before they came before this House. Now there are a number of subjects that the various Reference Committees dealt with and considered last night, and we will ask the Chairmen to present each subject separately and pause so that that subject may be settled before we go to the next matter. Now these reports are subject to discussion. As you know, we can make a substitute motion, you can approve or disapprove. This is the official body of the organization and your decision is final. I will do my best to preside over this meeting in a parliamentary way and try to expedite things.

The first Reference Committee report is the report of Dr. Robertson, Committee on Reports of Council and Officers.

DR. ROBERTSON: Mr. President and House of Delegates, if I may, I think it would expedite matters to read the complete report, unless there is some objection I will do so.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF COUNCIL AND OFFICERS

Report of the President: The President is to be commended for his tireless activity in behalf of the Association throughout the year. His enthusiasm and his leadership have given the Association a most successful year.

The Committee recommends the adoption of his report.

Report of the Secretary: The Secretary has completed another year of faithful service and to him the Committee would like to extend the gratitude of the Association. His work concerning the placement of physicians in communities where needed deserves particular mention. The Committee would urge the cooperation of all members of the Association in helping him place young physicians where they are needed the most.

Your Committee recommends the adoption of this report.

Report of the Treasurer: The Committee has received the report of the Treasurer and notes with pleasure the surplus of income over expenditures. The Committee wishes to again thank the Treasurer for a job well done and recommends the adoption of his report.

Report of the Editor: The pungent and timely report of the erudite Editor was received with great satisfaction. The Committee would like to call the attention of the House to the constant improvement in the standards of the Journal under his editorship. We recommend the support of the Association in all phases of his problems.

The Committee would like to take this opportunity to extend the gratitude of the Association for his work and recommend the adoption of his report.

Respectfully submitted,
Henry C. Robertson, Chairman
Charles N. Wyatt
R. L. Sanders
William T. Hendrix
James C. Warren

PRESIDENT SMITH: Thank you Dr. Robinson. Is there any objection? If not we will accept the report as read.

The next report is Legislation and Public Relations, Dr. Frank Owens.

DR. OWENS: Mr. President and Gentlemen, the report of your Reference Committee on Legislation and Public Relations. Certification of Psychologists; we recommend the President appoint a committee to meet with the Legislative Committee of the South Carolina Psychological Association to study proposed legislation concerning the certification of psychologists and to make recommendations to Council on any pro-

posed legislation concerning this matter. This was brought up at the request of Dr. Wallace. I move the adoption of that recommendation.

PRESIDENT SMITH: Is there a second? The motion is seconded. Any discussion? If not everyone in favor of the motion signify by saying aye. The motion is carried.

DR. OWENS: On the Sumter-Clarendon County recommendation on the establishment of a committee to investigate the desirability of instructing legal counsel to endeavor to get the South Carolina Legislature to establish a basic science law, we recommend that the President establish such a committee or refer the matter to the appropriate standing committee. I move the adoption of that recommendation.

PRESIDENT SMITH: Is there a second? The motion is seconded. Any discussion?

DR. EADDY: Might I ask him to read that once more please?

The recommendation is re-read.

PRESIDENT SMITH: Any further discussion? If not all in favor signify by saying aye. The motion is carried.

DR. OWENS: On the Anderson County request that necessary steps be taken to present to the Legislature legislation for the purpose of instituting the medical examiner system patterned after that in effect in Virginia to replace the present coroner system throughout the State, we recommend that the matter be referred to the Committee on Coroner Medical Examiners for a study on a state-wide basis with the request that a code of laws be compiled outlining the activities of the Coroner's office and that this committee make a recommendation on their findings to Council. I think this is a rather involved proposition, involving not only the coroner's office, but different problems in different sections of the State. It was brought out that the duties of the coroners are not clearly outlined under the present law and the thought behind this is that this committee would study the proposition and make recommendations as to any activities that the coroner's office should have. We recommend the adoption of that recommendation, and I so move.

PRESIDENT SMITH: The motion has been seconded. Any discussion? If not all in favor say aye. The motion is carried.

DR. OWENS: On the portion of Dr. Cain's report to our Committee, we feel that no action is necessary and we therefore recommend that it be accepted as information. We would also like to take cognizance of Dr. Cain's commendation of Dr. Charles Wyatt's work on Civil Defense and add our endorsement to this. We also recommend continued vigilance on the part of Council, our Legislative Committee and our legal counsel.

By that last paragraph we mean that the naturopath and the optometrist bills are not dead, although they are quiet at present, and we feel that continued vigilance is necessary to protect the rights of the medical profession and the people in those respects. I would like to move the adoption of that recommendation.

The motion is seconded.

PRESIDENT SMITH: All in favor of the motion say aye.

The motion is carried.

DR. OWENS: On the matter of a proposed Uniform Hazardous Substances Act, we feel that study of this and existing and proposed laws and Board of Health regulations are advisable before action can be taken. We therefore recommend that the matter be referred to the State Board of Health for its recommendations to Council. I recommend, or move the adoption of that recommendation.

PRESIDENT SMITH: The motion is seconded. Is there any discussion? If not, all in favor signify by saying aye. The motion is carried.

DR. OWENS: The report of the Committee on Public Health makes no recommendation. We therefore recommend the acceptance of the report as information.

PRESIDENT SMITH: The motion is seconded. All in favor signify by saying aye. The motion is carried.

DR. OWENS: On the recommendation of the Board of Medical Examiners, that there be an annual or semi-annual registration of all medical doctors, we recommend that the matter be referred to our legal counsel for a study of necessary legislation involved, and that he report to Council and that Council be requested to take such action as they see fit on the matter. I move the adoption of that recommendation.

PRESIDENT SMITH: The motion is seconded. All in favor say aye. The motion is carried.

DR. OWENS: Report of the Committee on Legislation and Public Relations, makes no recommendation and we therefore recommend that the Committee's report be received as information.

PRESIDENT SMITH: All in favor say aye? The recommendation is adopted.

The next Committee report is Public and Industrial Health, Dr. W. W. Edwards.

DR. EDWARDS: Mr. President, this report of the Reference Committee on Public and Industrial Health approves in principle of the resolution as presented by the Columbia Medical Society regarding nursing, and so forth. (The report is read). Your committee moves the adoption of this resolution.

PRESIDENT SMITH: Gentlemen, you have heard the recommendation. The motion is seconded. All in favor say aye. The motion is carried.

DR. JOE CAIN: Gentlemen, I rise to discuss this particular motion, because I want to give you Council's viewpoint on it, as was discussed yesterday, and this was not presented yesterday for your information. The Reference Committee got this letter cold and more or less by mistake, and we feel that such a recommendation that they have brought in is a



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little premature. When we went into this problem of nursing service to be rendered by the Duke Hospital, Duke Foundation, we found out that it was a service to be given by Duke Foundation, since they find they have surplus funds. And there seems to be some vague misunderstanding as to just how this was to be implemented. It first came to our attention by request of the schools of nursing of the Columbia Hospital and Spartanburg General Hospital, who told us their program was being held up because the South Carolina Medical Association had not approved this. And they told us it had to be a three-way approval, hospital association and nurses and medical association. Dr. Smith wrote to the Duke Foundation and

after an exchange of correspondence he got exactly nowhere and he got no recommendations as to whether or not the South Carolina Medical Association has to approve this or not. So in view of the fact that there seemed to be a misunderstanding and that we did not wish to get involved in any way with the program of the State Nurses Association, whichever one happens to be handling this—as you know there are two associations—Council made the recommendation that we would ask the House of Delegates to allow us to communicate with the Duke Foundation to get the facts in the case, and if it were necessary that any action on this be taken before next May when we have another House of Delegates meeting, that Council be given authority to act in the meanwhile. Otherwise we will bring the information back to the House of Delegates next year. Now it might be necessary, if it turns out to be a good thing, that we give our approval to expedite these services. And I would like to make a substitute motion that this recommendation of Council prevail rather than that report of the Committee.

The motion is seconded by Dr. White and Dr. Eaddy. PRESIDENT SMITH: You have heard the substitute motion, which is voted on first. Those in favor signify by saying aye. The substitute motion is carried.

The next recommendation.

DR. EDWARDS: Item 2, approval of the resolution from Columbia Medical Society regarding the immunization programs of the Health Department. It is recommended that a copy of this resolution, together with the approval thereof be forwarded to the South Carolina State Board of Health and to all secretaries of the component county medical societies. I can read that communication if you wish.

PRESIDENT SMITH: Gentlemen, you have heard the motion. Do you wish further information, or is there a second to the motion? The motion is seconded. Any discussion? All in favor say aye. The motion is carried.

DR. EDWARDS: Item 3, Approval of the report as published in *The Journal* of the Committee on Infant and Child Health is recommended. It is the opinion of this committee that membership on this committee be changed little if at all in the ensuing year. It is further recommended that the existing appropriation for this work be continued. I move the adoption of this resolution.

PRESIDENT SMITH: The motion is seconded. If there is no discussion it is carried.

DR. EDWARDS: Item 4. The Reference Committee recommends approval of the report of the Committee on Industrial Medicine and Health as published in *The Journal*. It is the information of this Reference Committee that Item 1, regarding loss of visual acuity was approved by the South Carolina Society of Ophthalmology and Otolaryngology at its last meeting in 1957. Approval of this matter by this House of Delegates is recommended. I move the adoption of this recommendation.

PRESIDENT SMITH: The motion is seconded. If there is no discussion all in favor say aye. The motion is carried.

DR. EDWARDS: It has come to the attention of this Reference Committee that many physicians of this Association who are engaged in compensation medicine have voiced certain dissatisfaction with the existing Workmen's Compensation Act and the administration thereof. The allegations react to the detriment of present and prospective industrial expansion in the State of South Carolina. Therefore, it is recommended that the South Carolina Medical Association through its House of Delegates, petition the Governor of South Carolina to appoint a committee to review the existing Workmen's Compensa-

tion Act and its implementations. It is further recommended that such committee include two physicians to be recommended by the President of the South Carolina Medical Association; representatives from the legal profession, to be recommended by the State Bar Association; and representative from industrial groups. I so move.

PRESIDENT SMITH: The motion is seconded. If there is no discussion, all in favor say aye. The motion is carried.

DR. EDWARDS: This Reference Committee recommends the approval of the following reports as published in *The Journal*:

The report of the Executive Committee of the South Carolina State Board of Health.

The report of the Committee on Maternal Health.

The report of the School Health Committee.

The report of the Committee on Rural Health.

The report of the Advisory Committee to The Crippled Children Society of South Carolina.

The report of the Committee on Care of the Indigent.

The report of the Committee on Public Health.

PRESIDENT SMITH: The motion is seconded. If there is no discussion all in favor say aye. The motion is carried.

DR. EDWARDS: Item 7, The Reference Committee recommends approval of the Report of The Cancer Commission as submitted to the House of Delegates.

REPORT OF CANCER COMMISSION

Members of this Committee, the Section of Cancer Control of the State Board of Health and the State Cancer Society appeared on several occasions before special Legislative Committees in support of a State Cancer Nursing Home for terminal cancer patients.

The state has been better organized for carrying on a worth-while public education program relative to cancer. The membership of the Professional Education Committee of the State Cancer Society has been extended to include members of the dental, nursing and pharmaceutical Associations. Professional cancer education has been especially geared to reach the latter three groups.

It is a pleasure to report that nine of the eleven State-Aid Cancer Clinics have full approval of the American College of Surgeons. All eleven State-Aid Cancer Clinics have a properly functioning cancer registry which records every patient, private and public, in-patient and out-patient, upon whom the diagnosis of cancer is established. According to these cancer registries approximately 3800 new cases of cancer were diagnosed and treated during 1957. A concentrated attempt is being made to follow-up all known cancer patients in this state. In order to accomplish this it is necessary for the private physicians to keep the registries informed on the progress of their patients. Such data is imperative in determining incidence, prevalence and 5 year cure rates. Your cooperation with the cancer registries is earnestly solicited.

Percy D. Hay, Jr., M. D.
Chairman

PRESIDENT SMITH: The motion is seconded. If there is no objection the motion will be accepted.

DR. EDWARDS: Item 8, The communication from the State Health Officer regarding sterilization of mental patients, not necessarily admitted to the State Hospital, and also, the control of radiation hygiene in the State, was reviewed. Your committee recommends indorsement in principle of both proposals as presented.

PRESIDENT SMITH: The motion is seconded. If there is no discussion, all in favor say aye. The motion is carried.

The next Committee to report is the Credentials Committee. There is no report.

Next, Insurance, Blue Cross and Blue Shield, Dr. Edward Parker, Chairman.

DR. GEORGE DEAN JOHNSON: Mr. President, Dr. Parker was supposed to have the report, I have not seen it since last night. He is probably still scratching his head over how to answer some of the problems.

PRESIDENT SMITH: When he comes in let me know.

The next Committee is Miscellaneous Business, Dr. Ben N. Miller, Chairman.

DR. MILLER: Your Reference Committee on Miscellaneous Business, Mr. President, reviewing the reports from *The Journal*; the first report is Dr. Cain's report of the Advisory Committee. (Council) Your Reference Committee would like to recommend acceptance of this report and so move.

PRESIDENT SMITH: The motion is seconded. If there is no discussion, all in favor say aye. The motion is carried.

DR. MILLER: The second is the Committee of American Medical Association Education Funds, Dr. Stokes gave a very able presentation yesterday which is recorded in *The Journal*, and your Committee recommends this be accepted.

PRESIDENT SMITH: If there is no objection, it is so ordered.

DR. MILLER: Number 3, Committee for Liaison, Dr. John B. Pratt, recording his report in *The Journal*, it has been reviewed and your Committee recommends its acceptance.

PRESIDENT SMITH: If there is no objection, it is so ordered.

DR. MILLER: Our able Editor of *The Journal*, Dr. Waring, reports on Committee of Historical Medicine. He says he has \$2250.00, and we move that he accepted.

PRESIDENT SMITH: If there is no objection, it is so ordered.

DR. MILLER: We had in our Reference Committee, Committee on Coroners-Medical Examiners, which apparently has been a little overlapped, and we acted on this report as recorded by Dr. H. R. Pratt-Thomas, and your committee would like to make a further recommendation as to that. It is the feeling of the Reference Committee that a concerted effort, through Council, should be made to promote legislation to set up a medical examiners-coroners type of system at an early date.

PRESIDENT SMITH: The motion is seconded. If there is no discussion all in favor say aye. The motion is carried.

DR. MILLER: Number 7, report of the secretary, he gave a very fine report and we would like to move to accept this as recorded.

PRESIDENT SMITH: If there is no objection, it is so ordered.

DR. MILLER: The report of the Executive Secretary and Counsel as presented by Mr. Meadors, yesterday, gives a detailed report with reference to activities in that area, there is nothing to be acted upon by this group, and we would like to recommend the acceptance of that report.

PRESIDENT SMITH: If there is no objection, it is so ordered.

DR. MILLER: Report by Dr. Weston from the American Medical Association as delegate to that body, gives a rather extensive report covering many areas, but some not covered in detail but in summary. There seems to be at least some comment by the House of Delegates. The Reference Committee report follows: The participation of the medical profession on a voluntary basis under Social Security was discussed in Dr. Weston's presentation. A study committee through Council was recommended by the Reference Committee. I move the adoption of this recommendation.

PRESIDENT SMITH: The motion is seconded. All in favor say aye. The motion is carried.

DR. MILLER: Dr. Wyatt's report on civil defense was read from the floor. We would like to commend him for his work and accept his report as given to the Secretary.

PRESIDENT SMITH: The recommendation will be ordered if there is no objection.

DR. MILLER: Dr. Mayer reporting from the State Committee of the South Carolina Highway Department, Safety Committee, indicates he would like to have the following resolution passed upon. (The resolution read). Your Committee would like to recommend that this resolution be adopted and so move.

PRESIDENT SMITH: If there is no objection, it is so ordered.

DR. MILLER: A further report of Dr. Mayer's committee indicates that a letter addressed to our President, number 1, recommends the following, driver re-examination, and 2, minimum age for procuring driver's license, which would be increased from fourteen to sixteen years. Your Reference Committee moves that that be done.

PRESIDENT SMITH: The motion is seconded. All in favor say aye? The motion is carried.

DR. MILLER: Dr. Frank Owens, reporting for the Medical Advisory Committee Selective Service System, indicates he has a standby committee that should be continued, and we accept his report and suggest it be adopted.

PRESIDENT SMITH: The motion is seconded. All in favor say aye. The motion is carried.

DR. MILLER: Dr. Wallace Cone offered a resolution regarding pay schedule from the vocational rehabilitation. We recommend that his resolution be adopted.

PRESIDENT SMITH: The motion is seconded. All in favor say aye. The motion is carried.

DR. CAIN: Mr. President, I would like to discuss that a moment.

PRESIDENT SMITH: All right sir.

DR. CAIN: Gentlemen, I am not speaking for or against this recommendation, but I would like to get a little more information on it before we vote. I have gone into this problem with the representative of the Vocational Rehabilitation on one or two occasions, and I found the same trouble that Dr. Cone found. The answer I have gotten and which I have accepted because I believe it to be the only thing to do, was that with this type of patient all our fee was a token service and we should be satisfied with it. Whether that should be I don't know. But I would like to have someone to comment on this fee schedule or someone who helped work out this fee schedule in the beginning, I would like to know a little of the background before we go upsetting it. If it has to be re-worked, then I believe the entire fee schedule should be re-worked, not only a request for surgical assistance. Is there anyone here that could give us that information.

DR. MILLER: I would be glad to discuss this, because I do have firsthand information about it. In the next few weeks there will be a meeting of the Guidance Committee, which will review this whole problem of fee schedule, and this point covered by the resolution asking that a fee be established for an assistant is one of the top matters on the agenda and it will be acted upon, and I am sure that you will not be unhappy with the passing of this resolution, because the whole fee schedule will be reviewed and this will be a part of the review.

PRESIDENT SMITH: Any further discussion? Would you mind giving your recommendations in brief?

DR. MILLER: It is recommended that Dr. Cone's

resolution indicating a fee for a surgical assistant be accepted.

PRESIDENT SMITH: Any further discussion? If there is no objection the recommendation will be accepted.

DR. MILLER: Committee on Permanent Home, Dr. Guess, Dr. Hanckel, Dr. Lawrence, Dr. Mayer, reported that studying in this field was well under way and recommended the study committee be continued. And we accept their report and recommend its adoption.

PRESIDENT SMITH: Any further discussion. If there is no objection the recommendation will be accepted.

DR. MILLER: The last item on the agenda of the Reference Committee had to do with the question of the Liaison Committee between the South Carolina Medical Association and the Medical College of Charleston. Dr. Smith appointed a committee, Chairman Dr. Frank Owens, to work on this and they came up with the recommendation that no liaison committee be established. Two additional items in the same area were presented, one by Dr. Prioleau and one by Dr. Baxter, president of the Georgetown County Medical Society. Your Committee had a fairly extensive hearing on this and a detailed hearing was held by the Committee regarding a Liaison Committee between the Association and the College, and the recommendation is that the report presented by Dr. Owens, after careful study, that no liaison committee be established, and your committee so moves that this report be accepted.

PRESIDENT SMITH: Any discussion?

DR. PRIOLEAU: Mr. President and members of the House of Delegates, this is not just to have a last word, but it is that we want to thank the Reference Committee for its patience, and for its work, and if it is in order too, for me to commend the President on the way in which he approached the problem by setting up a committee from different parts of the state to look into the problem and give their advice. Naturally I have great respect for that committee and also for the Reference Committee, and I have no idea of reopening the discussion today, and certainly not for the time being. Now in the resolution as regards the term practice of medicine in connection with the Medical College hospital, there was no idea of implying corporate practice. I don't know what word should be used, but there was no question of that, and if there should be any question in your minds, please remove it. There is no insinuation or implication of that nature.

Of course, in order to work together, it is important that both bodies have knowledge of what the other is doing.

One more point, as regards the present status. We all have problems, troubles, local economic troubles. Roper Hospital is still an important factor in medical education and in the Medical College set up. It provides from county appropriation \$500,000.00 worth of indigent patient care per year. Now this is for patients of great value in undergraduate teaching. Now our local liaison has not been effective, maybe it can be made effective. I am going to give you one example, and that is the differential in, say room rents, for private patients, in both hospitals, Roper and Medical College. There is a differential from a patient standpoint in favor of the Medical College hospital. When the nurses salaries were raised, Roper had to announce in the paper, that room rates would go up, effective such and such a date. Saint Francis had to follow. The administrator of the College hospital was asked whether or not that would affect it in the same manner, and we were informed it would not necessarily affect the room rates in the College Hospi-

tal. And when I say we have economic difficulties, we do. Now to get down to the last point, from a more general standpoint. There are two ideologies, and I think this is really what counts. I understand perfectly the philosophy of the administrator of the College hospital, it is that they are doing a good job; well, we agree to that. But they think they can do a better job and continue to do it, if more or less left alone. The College hospital is growing, and medical education is dependent upon intermingled, the care of patients in all economic categories, and problems are going to arise. My philosophy is that in the matter of the medical hospital and the medical profession, it would be to the advantage of both if they go along together, through some form of committee.

PRESIDENT SMITH: Any further discussion on the motion before the House?

DR. PARKER: I would just like to ask, if the recommendation of the Committee is carried, is there any plan of the House of Delegates for continued serving of this committee or will it be amended.

DR. OWENS: Mr. President, maybe I can answer that question. It was the thought of our committee in making that recommendation that that was final. There would be no committee formed, period.

DR. K. M. LYNCH: Mr. President, and members of the House of Delegates. I would not have dissented this question here this morning, except that discussion has been already indulged in and made. I understand that the question before the House is a motion to adopt the Reference Committee report, is that correct?

PRESIDENT SMITH: Yes, sir, that is correct.

DR. LYNCH: And the Reference Committee report is, (I was not here because I did not expect this to arise,) to adopt the special committee report?

PRESIDENT SMITH: That is correct, sir.

DR. LYNCH: I would discuss this question further, because the same sort of statement has been presented even since I came into the room, as was presented before the Reference Committee last evening. Had it been left to the judgment of the Reference Committee, I would have said nothing more, because I thought all that should be said was said there, unless the subject should be reopened and carried further.

I am in something of a quandary about whether it is at all necessary to reply to some of the statements of the previous speaker, just made, after having made those statements last night before the Reference Committee, and where they should have been sufficiently stated. Since they have been re-made here, I think there are certain things which it is necessary to say in order to keep in the clear, perfectly clear answers to what really constitutes accusations and charges which still appear to me are being made. When it was in prospect that this subject, even though it was thoroughly discussed last year, and in my opinion should have been left as this House of Delegates left it last year by 78 to 7 vote, or something like that, it should have been left there because that was the action of the House of Delegates. But it wasn't left there. Therefore it is kept in mind. In the course of thinking over the matter and what was proper and a dignified approach under the present circumstances. I took the occasion to review the whole story of this movement from 1944 up to now, 1957, when the present flurry first occurred. And it was amazing to me. As you may have noticed when I came in the room, I had with me a bound volume, that is the first years only. There are ten bound volumes of newspaper clippings, that much newspaper clippings. The



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other documents concerned are in files, and I could only of course transport here a small part of those files. It would have taken a truck to bring those files anywhere outside of my home. That is the extent of the record which exists in this matter, during the course of which the same sentiments in much the same words were said in 1945 and 1946, and unfortunately by the requestors or resisters (as far as I am concerned it might as well be called) unfortunately displayed in the public press, which the Medical College tried to keep out of. In the needling processes of the public press, however, that is not an easy thing to do, and sometimes can't be escaped. But there are expressions, there are publications, there are statements which for the dignity of the profession of medicine and the dignity of a modern medical school, never should have been there nor should have much of what was said and done otherwise. Now much of that, or most of it stopped as of December, 1947, when the Governor of South Carolina signed the bill which set the construction program on its way, and at which time resistance to the program of the Medical College in the development of its plan which was approved unanimously by the House of Delegates of that year and by every other organization which is concerned in such matters in medical education. However, to our surprise, there was an unheralded renewal of the same type of resistance which occurred more or less abruptly, or at least to many people a surprise move last year, and it went the same course as it has now been renewed this year. That is, statements to the effect that it was referred to a committee after having been studied in the intervening years by a special committee appointed by the President, and which reported that no such, I hesitate to use the word "liaison," because it is in error, it is not a liaison committee, but that this subject shall not be further considered at this time, that was the sense of what everybody said. And that was referred to the Reference Committee last night, where it thrashed out the subject in considerable detail, and I understand, although I wasn't here when the Reference Committee made its report, that its report bore out the Special Committee appointed by the President, that no further action in this matter should be taken at this time. And the reason why I believe it was worded that way, is because of the nature of the proposal in truth, not as a liaison committee at all but as an investigation of the Medical College and an investigation of their plan and program, where there has been no evidence presented whatever why there should be any investigation. An investigation itself, the question of investigation carries certain implications, but I can assure this organization that there is nothing behind the blackboard in the Medical College planning or its course of procedure or what it has done or what it is doing. It is written straight out on the top of everything, and anyone who doesn't know, either hasn't listened or read or hasn't wanted to, one of those things. It is perfectly straightforward down the line.

Now, in view of what I heard the previous speaker say after I came in, I am going to take the liberty of reading, so that it will be again a matter of record, a certain section of what I have written in case the whole story should be exposed here. All this has been in the hope that none of that would ever come to eye or ear again, until it has become a matter of history and would be in the light of an interesting episode of the development of this old and honorable school, just as the almost identical occurrence in 1820 to 1830 or in there, is now a matter of history. And it is most astonishing that it was about the same subject and to the same point that ultimately the practicing profession in Charleston, who had objected to much the same thing, that is, the operation of a teaching

hospital by the new faculty of the new school in Charleston, one of the first if not the first teaching hospital ever organized and operated by a medical school faculty in this country, was organized and operated by the faculty of the original medical college with which we are connected. And the members of the medical society felt that they were being infringed upon, just as it appears that somebody here feels his activities are being infringed upon. And there was a period of several years, and confusion and turmoil until the profession, which was not immediately concerned with the medical school operation or medical education, came to the conclusion that they had no business raising such questions and carrying the thing any further, and they turned it back, where it rested for many years, and now has to be pulled out again, which I think is most unfortunate, absolutely unjustified; there is no basis for it and there has been no evidence presented upon which any revival of that sort of thing would be justified at all.

Now, with your indulgence I am going to read this statement so that at least it will go into my record of the story of that affair. It has a brief preface and then it consists of an analysis of the presentation of the subject of State Association—Medical College Relations, which appeared in the most recent issue of the South Carolina Medical Journal, an analysis of that article because it was in writing, it is recorded and it says all of the things that have been said by the writer during the course of his discussion.

"In order that the Medical College might qualify for continuation of its long and honorable career, and in order to provide for the physical facilities, the essential faculty, and the operational support required for recognition in a present-day educational program in the health professions, the authorities of the institution have for the past fourteen years been involved in the development of an expansion program" as it was recently called. It has expanded now, it is not exactly the correct term now. The expansion has mostly already occurred. "With strong support from the South Carolina Medical Association, as well as all other related professional and legislative bodies, this effort has met with signal success.

"Without reciting again the long story, it can be assumed that the principal events of its course are familiar to practically everyone concerned" or at least they should be. "The several steps can be called to attention whenever desired; they are well recorded, documented and published.

"In the course of this development, close relations have been kept with all associated organizations and institutions, and with those working in cooperative operations with the Medical College interinstitutional committees" already established, long established. It was questioned last night with this statement that they don't work. Well now, tell me please how in the world do you expect a liaison committee of any type to work between the South Carolina Medical Association and the Medical College, if the existing liaison committees between the Roper Hospital and the Medical College and between the Medical Society that owns and operates Roper Hospital and Medical College do not work? As a matter of fact these liaison committees have long been set up. Once the major one, that is between the medical society, which is not any longer the county medical society, but the corporate owners of Roper Hospital, that was called into play once, when there was a question of who should continue to operate the outpatient clinic, it having been located in the Medical College, and the Roper Hospital having managed it with support from the county and the Medical College, and having notified the Medical College that it was discontinuing that because the county had not made sufficient appropri-

tions, notifying the Medical College of that fact, whereupon the Medical College took over and reopened it and that has been running continuously since. It was in that question, which was one of mutual interest, that the liaison committee was called into action, and steadily, so far as the record goes and so far as action taken, steadily satisfactory. Now if we can't, with our closeness, the circumstances in Charleston, make a liaison committee an active working committee, where will you expect any such thing to occur. I do not admit that it hasn't worked. It has never been called on but that once, that is all. Not subject to call at any time, and I think I heard Dr. Prioleau say that much of what he was talking about was of local nature. All anybody has got to do is to approach the proper route for it and not jump all the way from himself as an individual doctor to the State Medical Association, when there are forums through which he should go first.

Continuing "In setting up the operational organization and rules of control, the Medical College has strictly adhered to the principles generally accepted in the field of medical education, including the requirements of law as well as the principles of ethics in professional relations as recognized by organized medicine." That pretends to say why it was necessary to make a record of what I might have said under perhaps more pressing circumstances. But in order to clear some of the points which I believe are still confusing, from what I heard Dr. Prioleau say, I am going to make this statement. "The statement is made, and repeated, that the Medical College Hospital," and by implication "as a State institution, is engaging in the practice of

medicine." Now nothing could be more untrue than that. The Medical College Hospital is less likely to have any opportunity, and actually has less of anything that could be questions as the practice of medicine, than any hospital that I know of. There might be a charge or an accusation against a certain area in the Roper Hospital practicing medicine, but you couldn't make the same charge against the Medical College Hospital. There might be in some other hospital, particularly the laboratory provisions, where certain things have not been brought in line in accordance with recent court decisions, but the Medical College Hospital is free of any evidence that could be presented of the charge of practice of medicine as any hospital that ever existed or ever will exist. Now regardless of whether or not anyone claims that they didn't mean that, the words say that. The practice of medicine is the practice of medicine. And hospital operation is a facility of providing the place to bed down a patient, if needed, for hospital attention, and facilities that go with that for use of practice of medicine. The hospital is not practicing medicine. The setup is one of its basic principles that the institution cannot and will not enter into the practice of medicine or collect money for the professional service of its staff, and make a profit off of it. That is improbable, it is even impossible in law, in accordance with the opinion of the Attorney General, through whom we cleared it to make certain we were absolutely protected in the matter. We carried it to every point we could think of, to protect against that very charge or suspicion, which is perhaps justified in some other hospital operations but not in this one.

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Continuing "It is also provocative of misapprehension to state, even in the negative form, that it should not be forced to seek income from that field of patient care commonly considered the province of the community hospital. The Medical College Hospital does not, cannot and will not seek income from patient care. Further it does not and will not undertake to attract patients who can secure adequate service in their home communities. It strictly limits admissions of patients to those referred by home physicians to named members of its staff," not to the hospital, not to the staff, a reference of the home physician to a named member of the staff, and I can guarantee that because I get a list of every patient every day that was admitted, who the referring doctor was and who the doctor was the patient was referred to, even the so-called service cases. That is true. They must be referred by the home physician and to a designated member of the staff.

"Still further, it has refused and will continue to refuse community hospital contracts or any other type of admission of patients except by referral from private practitioners to members of its staff for specified services." I think mention was made of the fear, it has been expressed before, I believe it was made here, the fear that the Medical College will absorb the province of Roper Hospital in its care of the community supported patients in Charleston. There again, we are not only protected by a flat no all the way, and everybody knows that, including the General Assembly, and I can assure you the General Assembly will not succumb to any political requirement that the Medical Hospital take that over, because the Attorney

General has already ruled that is not in the law. That is, the law upon which it was built did not contemplate the relief of any county in its county responsibility. We have not been idle in these things.

Continuing "The Medical College Hospital has not found it difficult to enforce this referral system strictly, as questioned in the article." As I told the Reference Committee last night, I recalled one instance of a violation. I am the one that violated it last week. The head of the Department of Obstetrics came to me and said a member of the staff, a member of the faculty in the Department of Obstetrics was in an emergency, he had a difficult obstetrical case in labor and not another bed in Charleston to place the patient, and I said bring her in. We don't work on a literal application of the rules, we are a hospital, and that is the only violation I am aware of. And I don't know of any other, because I have the records, and I approved it myself.

"The repeated charge that the Medical College Hospital is interfering with community hospital operation in various ways is without foundation." I think I have already explained the most important contention of that sort, that was the Roper Hospital. There needs be no fear whatever on the part of Roper Hospital, I can say that and guarantee it, because it is fixed, any thought of intruding into the province of Roper Hospital as a community hospital, if it will preserve it, not if it doesn't preserve it, the community will have to look into that. That I say is without foundation.

"The comparison drawn in the article between room rate charges is inaccurate and misleading. While the

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1. Thomas, J. W.: Ann. Allergy 16:128, 1958

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room rates at the Medical College Hospital were arbitrarily set" in the beginning, before it was opened, "not to undercut other local hospitals, but to range somewhat higher in the best accommodations, there may be revisions after full completion of the opening period," as we go along in the experience, in the operation of the hospital, but the rate was set that way, taking into account Roper Hospital rates, so we could not be guilty of undercutting them, and they are not undercut. They range a fraction high in best accommodations. Whether or not changes shall occur will depend upon conditions as they evolve. "Presentation of comparisons of the complete rate structures, instead of partial items, as done in the article, would have been enlightening, and probably would have given reassurance instead of misapprehension. The fact that some hospitals are old and some new, with consequent differences in comforts and accommodations, has no bearing. Practically all new hospitals, built or planned" including the plans of the new Roper addition, whose building committee I am honored to be a member of, "include air conditioning and better toilet and bath facilities." And when those are provided they will be available too, as they are in the Medical College Hospital.

Dr. Lynch continues the reading of the statement.

DR. LYNCH: Mr. Chairman, I think that perhaps I have talked enough and have said enough to indicate the answers to the continued propositions which have stirred up this question again. And if I have not cleared all questions, I am open to such inquiries at any time. I am certain that I can assure you all that the Medical College, and the operation of its hospital by the Medical College, infringes on nobody. It adds to what the profession of South Carolina may need in addition to furnishing the clinical facilities which were required for the continuation of an acceptable school of the present day. It is my understanding that all of the thrashing around that has been done has arrived each time to the same point, and I do hope that the House of Delegates will end this flurry once and for all and give a proper opportunity out of a harmonious and friendly situation for the development, further development and for the continued proper relations between the profession and their medical school. Thank you very much.

PRESIDENT SMITH: Thank you, Dr. Lynch. Gentlemen, there is a motion before the house. Is there any further discussion? The motion, will you read it again Dr. Miller?

DR. MILLER: The Reference Committee would like to state that they acted favorably upon the recommendation of Dr. Owens' Committee and report as follows: After careful study the Committee recommends that no liaison committee be established at this time. I so move.

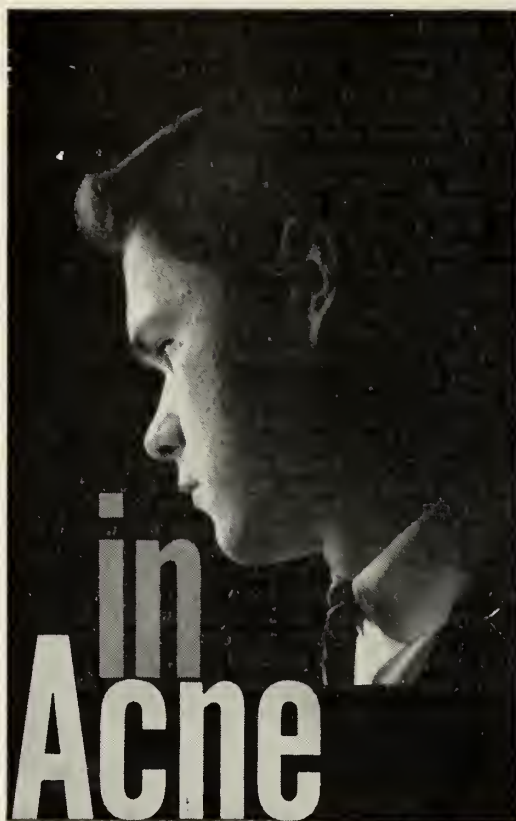
PRESIDENT SMITH: If there is no discussion I would like to call for a standing vote. Everybody that is in favor of the motion please stand. Now those opposed please stand.

DR. WESTON: Mr. President, as Chairman of the tellers, there are seventy-one in favor and six against.

PRESIDENT SMITH: You have heard the report of the tellers, the motion is carried and so ordered, as read by Dr. Miller. Dr. Miller, do you have further reports?

DR. MILLER: That completes the reports, sir.

(To Be Concluded)



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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.

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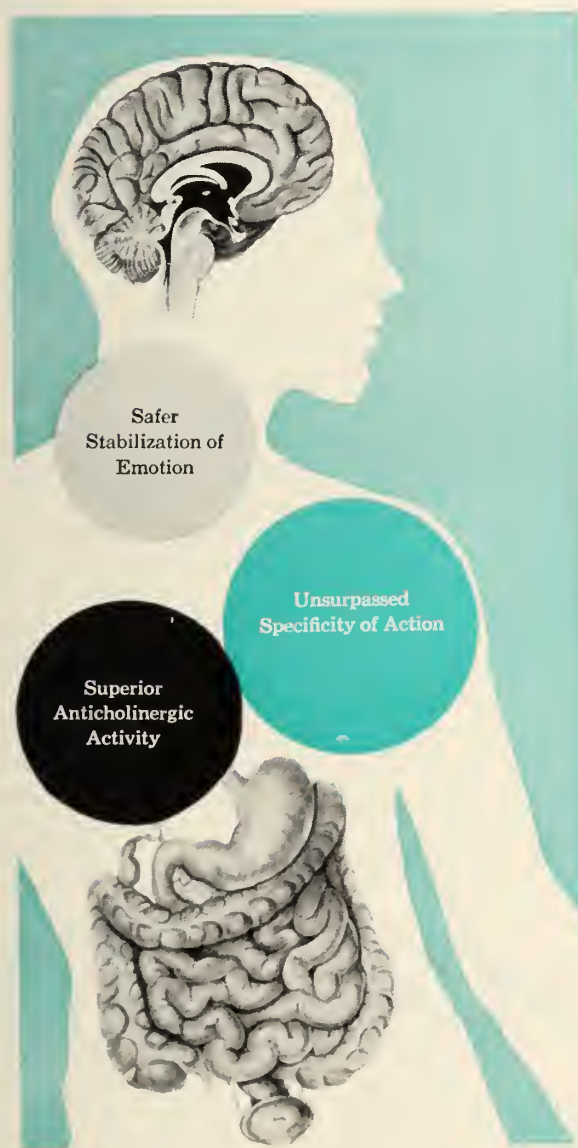
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BOOK REVIEWS

MODERN CLINICAL PSYCHIATRY, Fifth Edition. Arthur P. Noyes, M. D. and Lawrence C. Kolb, M. D.; W. B. Saunders Co., Philadelphia—1958. Price \$8.00.

The fifth edition of this classic textbook on basic psychiatry constitutes, as did its predecessors, a very thorough, comprehensive and lucid exposition of this rapidly growing specialty.

As in previous editions, the authors have maintained a dynamic orientation and elaboration of the factors involved in the causation of mental disorders. It is enlarged and expanded to encompass the many contributions to psychiatric thought that have emerged since publication of the fourth edition about five years ago. Although previous editions were written by Dr. Noyes alone, the current volume is coauthored by Dr. Lawrence C. Kolb, Professor of Psychiatry, Columbia University.

There has been some rearrangement of the subject matter and the nosology conforms with the revised nomenclature enunciated in the Diagnostic and Statistical Manual of Mental Disorders, a publication of the American Psychiatric Association. Extensive bibliographies document each part of the text. The first quarter of the book is devoted to personality dynamics, the second quarter to a discussion of organic mental disturbances and the remaining one-half presents the disorders of psychogenic origin.

One chapter is devoted entirely to the psychophysiological autonomic and visceral disorders, more commonly referred to as "Psychosomatic Disorders", and the subject matter is treated very thoroughly. This chapter replaces one titled "Psychiatry in General Medicine" that appeared in an earlier edition. All the psychoses of psychogenic origin are discussed under five chapters bearing the general title "Psychotic Disorders".

Two new chapters have been added. "Pharmaco-

logical Therapy" presents a concise evaluation of the more frequently used tranquilizing drugs that are now enjoying such widespread favor. The concluding chapter on "Psychiatry and the Law" contains a brief discussion of the areas of psychiatry that overlap with the social control of behavior and the proper safeguarding of the patient's civil and criminal rights.

The latest edition of this respected text will continue as the "Bible" of the specialty in the student's library, and general practitioners as well as psychiatrists will find it a superb book for reference and refresher purposes.

William S. Hall, M. D.

PSYCHOSOMATIC MEDICINE; A Clinical Study of Psychophysiological Reactions by Edward Weiss, M. D. and O. Spurgeon English, M. D. Third Edition 1957. Price \$10.50. W. B. Saunders Co.—Phila.

This is the third edition of a book which has been well accepted in the field of psychosomatic medicine. It offers material bearing on the role of the psyche in relation to illness and discusses subjects which are perhaps not yet incorporated adequately in medical texts.

The book is well written and authoritative. While its background is Freudian, it represents a transition toward concept which has changed much in recent years.

O.B.C.

HOW TO LIVE WITH DIABETES. Henty Dolger and Bernard Seeman. W. W. Norton & Co., Inc., New York 1958—Price \$3.50.

A book for diabetics, with clear explanatory accounts of the history and the various phases of diabetes. It includes considerable discussion of tolbutamide (Orinase) and its indications.

This is a well-presented collection of facts and advice which does not trespass on the physicians' ground. It should be very useful.

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CHEMOPALLIDECTOMY FOR RELIEF OF PARKINSON'S DISEASE

WITH REMARKS ON SELECTION OF CASES FOR OPERATION AND
IMPROVEMENTS IN SURGICAL TECHNIQUE

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Many years' medical and surgical efforts have been carried out to relieve the very disabling tremor and rigidity that accompany moderate to far-advanced parkinsonism together with the masked facies, festination gait and ultimate invalidism and wheelchair existence that so often is the end-stage of this disease. It was first described by James Parkinson in 1817, an English physician. There are between 500,000 and 1,000,000 victims of this disease in the United States today. In many cases, it is thought to be due to pathological lesions (thrombosis, softening, old inflammation) occurring in the basal ganglia, particularly the *globus pallidus* or the thalamus on one or both sides of the third ventricle, involving a portion of the lenticular nucleus. Most commonly, parkinsonism appears to follow an attack of encephalitis, perhaps more than ten or twenty years after the original illness, such as those cases that followed the 1918 outbreak of influenza. In elderly patients, the disease appears to be associated with cerebral arteriosclerosis and thrombotic lesions in the basal ganglia. For many years, physicians have resorted to various drugs, particularly of the belladonna

group, for its medicinal treatment. In 1947, a synthetic chemical known as Artane (tri-hexyphenidyl hydrochloride) was introduced by American investigators and this marked a considerable advance in the medical treatment of this disease. However, there were some patients who could get only temporary benefit from it and who, after a few years, began to have the rigidity and tremor as badly as ever. Some patients could get no immediate or even remote help from the drug. As early as 1890, surgeons began attacks on the central nervous system in an effort to relieve the disabling tremor and rigidity. The first procedures were accompanied by a high percentage of fatality because of shock and infection. With the introduction of modern anesthetics, sulfa drugs, antibiotics and blood transfusions, the mortality of brain and spinal cord operations as a whole dropped markedly. During the late 1930s, surgical attacks on the pyramidal tract system for relief of parkinsonism either in the brain or the spinal cord began. However, it was found that whenever the pyramidal tract itself was divided, although the tremor and the rigidity would stop or be greatly reduced, there usually was an accompanying moderate or complete paralysis of the involved side so that it was a question which was the worse, the disease or the result of its surgical treatment!

^o From the Department of Neurological Surgery, Medical College of Virginia, Richmond.
Read at the Annual Meeting of the South Carolina Medical Association, Myrtle Beach, S. C., May 14, 1958.

The globus pallidus provides a series of efferent pathways which afford egress to the extrapyramidal motor stimuli which reach it. In fact, the efferent pathways from the globus pallidus provide a common final pathway for extrapyramidal tracts originating in the cortex, caudate nucleus, substantia nigra, putamen and thalamus.

In recent years, several investigators have devised procedures which are directed toward the basal ganglia. Review of the several surgical techniques demonstrates that of all surgical methods for the alleviation of parkinsonism, the most successful are those which have attacked, at least in part, the globus pallidus, the thalamus, or its efferent pathways. Moreover, the principal site of infarction following anterior choroidal artery occlusion is in the mesial globus pallidus. Therefore, it is apparent that a marked alleviation of both tremor and rigidity may follow the destruction of this anatomical area. There is considerable reason to believe that the globus pallidus exerts an excitatory or facilitory influence on motor activity which is initiated by the cerebral cortex and mediated by the pyramidal tract. The operation of chemopallidectomy is directed towards the more or less complete destruction of the mesial globus pallidus.*

Neurosurgical operations on the cerebral cortex for involuntary movements were originated by Sir Victor Horsley who excised the precentral (motor) cortex in cases of athetosis as early as 1890. Operations which were devised to resect either the premotor cerebral cortex (area six of Brodman) or motor cerebral cortex (area four) were introduced by Klemme and by Bucy approximately twenty years ago. Bucy stated that cortical extirpation is most effective when it includes both cortical areas four and six of Brodman. This operation produces a contralateral hemiplegia which subsequently lessens in severity leaving the patient with a residual hemiparesis but without tremor. Epileptiform seizures may develop following this operation. Rigidity and incapacitation are not decreased and may, in fact, be increased by cortical extirpation. As

*At a recent symposium at Irving Cooper's Clinic in New York (May 1958) it was emphasized that the ventro-lateral nucleus of the thalamus should also be destroyed at operation to eliminate tremor.

a result of his investigation, Bucy stated, "Nothing in my experience leads me to believe that it is possible to abolish tremor by any procedure which does not interrupt the pyramidal tract or destroy that portion of it which arises from the precentral gyrus." This conclusion stimulated others to attack the pyramidal tract at levels below the cerebral cortex. Putnam devised the operation of pyramidotomy which consists of incision of the pyramidal tract at the level of the second cervical segment of the spinal cord. Earl Walker developed an operation on the pyramidal tract in the cerebro-peduncle. This operation is referred to as pedunculotomy. According to Walker, a compromise with paralysis and freedom from tremor is the best that can be expected from pedunculotomy or from other operations aimed at the pyramidal tract either at the cerebral cortical or spinal cord level. Such operations were devised solely to relieve tremor and they succeed only in this respect at the expense of motor power. It has now been demonstrated that tremor and rigidity can be relieved without necessarily sacrificing motor power by chemopallidectomy, our present operative procedure for parkinsonism. Therefore there is rarely if ever any indication at the present time for purposeful destruction of the pyramidal tract with resultant hemiparesis as previously carried out in the treatment of parkinsonism.

Russell Meyers of the State University of Iowa began a new surgical era with a radical surgical technique which he utilized in a small series of patients with parkinsonism. He incised the basal ganglia only, avoiding the pyramidal tract, by operating through a cerebral lateral ventricle. In a significant number of his patients, the operation relieved the tremor and the rigidity without producing paralysis. However, he did not think the procedure was generally applicable as the post-operative death rate was in the neighborhood of 20 percent in his series of cases. The importance of Meyers' research, however, was that he had demonstrated the "target area," surgically speaking. It remained, therefore, for neurosurgeons to find some way to destroy this area (basal ganglia) without unduly harming other nearby regions such as the

internal capsule and to promise an acceptably low operative mortality. In 1952, Wycis and Spiegel of Temple University began stereoecephalotome operations on the brain in which they destroyed by electrocoagulation the suspected area of the basal ganglia with very promising results. Within three months after their first stereotaxic operation on a patient with Parkinson's disease, Irving Cooper of New York University, while operating on a patient with Parkinson's disease (Oct., 1952), planning to do a pedunculotomy which would produce very probably an associated hemiplegia, had the "happy misfortune," as it turned out, to have a severe hemorrhage develop during the operation and it was necessary to clip several vessels rapidly to stop serious bleeding. After the operation, the patient showed immediate remarkable improvement in the tremor and the rigidity although no nerve tracts had been divided and there was no associated hemiparesis. Cooper then found by further studies (angiography) that it was the anterior choroidal artery that had been divided, and he therefore proceeded to divide deliberately by open operation the anterior choroidal artery in patients with Parkinson's disease, attempting to produce a thrombotic softening of the globus pallidus by this operation. This was fairly satisfactory in the younger groups of patients, but was accompanied by a post-operative mortality in the neighborhood of 10 percent and also was not applicable to people over 50 to 55 years of age. It did, however, reduce the tremor in about two-thirds of the cases and the rigidity in three-fourths of the patients. He then thought of injecting novocaine in the basal ganglia through a small catheter in the brain to determine whether the tremor and rigidity would be helped by the proposed procedure of anterior choroidal artery occlusion later on. A step beyond this thought, naturally enough, was that if the novocaine eliminated the tremor temporarily, why not inject deliberately a small amount of a destructive chemical such as absolute alcohol into the globus pallidus for its permanent destruction at the same time or immediately after the novocaine demonstration of temporary elimination of the tremor? This final idea, then, paved the

way for the operation as carried out today for parkinsonism; namely, destructive chemopallidectomy with alcohol placed in the globus pallidus (mesial portion) or certain thalamic nuclei on one or both sides, in separate operations, as indicated in the individual case.

At the Medical College of Virginia, we began to carry out this procedure of chemopallidectomy in April, 1956, and have found it highly satisfactory in selected patients. In many cases, they seem many years younger within a few weeks of the operation in expression, gait, and general appearance. There is very little evidence, if any, of a hemiparesis after chemopallidectomy or other more serious complication post-operatively as used to occur with the old operations on the pyramidal tract (cited above). In six weeks to three months after the first operation, the other side is usually done if the patient has bilateral disease.

There are many theoretical objections to the use of absolute alcohol as a destructive agent in the brain. It is possible that electrolysis, radioactive substances, ultrasonic vibrations or radiofrequency lesions may prove to be preferable in the future. In our own experience, however, absolute alcohol has produced desirable and lasting results when properly employed. Therefore, its use is warranted until our own experience with other means of destruction of neural tissue or the documented experience of others proves some other agent to be superior. However, any neurolytic method can be utilized with this simple technique of globus pallidus puncture.

Chemopallidectomy is a technique which is potentially capable of widespread use in elderly individuals as well as the younger patients. It is a reasonably safe and accurate procedure; the chief obstacle to its successful use, in our experience, is the presence of very large lateral ventricles (cerebral atrophy). It has the advantage that the surgeon may withhold the completion of a permanent destructive brain lesion in the globus pallidus with alcohol until the likely effects of the operation have been estimated by intracerebral procaine injection. This ability to predict the probable result of operation in a

given case adds both to the safety and the possible success of the procedure. Moreover, slow injection of alcohol permits one to graduate the size of the lesion depending upon response in a particular patient. The technique includes, therefore, a meticulous orientation of a brain cannula by means of pneumoencephalography, verification of the site by injecting procaine first to observe the temporary effects in the contralateral extremities, and finally, injection of a destructive chemical agent, usually alcohol, to destroy permanently the active focus in the involved globus pallidus. Good lasting results (with respect to amelioration of tremor and rigidity) are obtained in from 60 to 70 per cent of the cases in most series which have been done throughout the country. Certainly, analysis of complications and failures will improve the still mobile methods of selecting patients and the surgical technique. Undoubtedly there will be improvements in the future. It has now been demonstrated beyond doubt, that the tremor, rigidity and marked impairment of gait can be greatly relieved or improved by this technique *without loss of motor power*, even in long-standing, far advanced cases.

As emphasized by Cooper¹⁻⁶ in several publications in the last few years, further efforts are certainly justified to improve the present surgical technique directed toward destroying the mesial globus pallidus or portions of the thalamus and also to improve the selection of patients and lessen the risk of operation. The operation can be done in quite elderly patients, as stressed at the beginning of this paper. However, we tend to withhold operation today from this "advanced age group" as we now prefer to do the operation in patients who are ambulatory, if possible, rather than those who are bedridden and confined to wheelchairs. It is anticipated that not only will improved surgical therapy ensue with the further development of these techniques during the coming years, but also that contributions will concurrently be made to improve understanding of the pathological physiology of parkinsonism and other hyperkinetic diseases. The gravity of the problem and the present deficiencies of *medical* therapy appear to justify intensive surgical efforts in the con-

trol of this disease. Certainly, the present surgical technique seems more promising than any other procedure that we have observed or encountered in the literature in over 25 years of continuous study of neurosurgical problems. Useful alleviation of many of the symptoms of parkinsonism may be obtained by chemical destruction of the globus pallidus or portions of the thalamus as outlined in this paper. Therefore, the advisability of employing this surgical procedure should be considered in many patients who have reached the moderately advanced stage of the disease and who are not controlled by medical therapy. The operative mortality is very low (2 to 3%). In considering surgery for a particular patient, one should evaluate the degree of disability, the duration of the illness, response to medication, prognosis and probable life span of the patient himself. Since far-advanced incapacitating signs and symptoms of parkinsonism can be relieved in many cases, one cannot conclude anymore that parkinsonism in any individual patient is necessarily a hopeless, irreversible syndrome, which has been the opinion among many careful students of this disease in the past. The modern concept in surgical therapy now is that *both tremor and rigidity may be relieved without sacrificing motor power*. In fact, the most hopeful approach to the neurosurgery of parkinsonism at the present time is destructive chemical surgery of the basal ganglia, particularly the globus pallidus or portions of the thalamus. Such long-standing relief has been demonstrated in many patients. In some cases, other stigmata of the disease have been alleviated as well. In addition to the perfection of surgical techniques as an immediate problem particular attention should be paid to the *selection of patients* in the future as possible candidates for neurosurgical therapy and to the development of a more useful classification of patients with a parkinsonian symptom-complex. In order for these potentialities to be realized, patients must be cautiously and judiciously selected as candidates for the operation of chemopallidectomy.

Further technical developments are¹ those related to the use of ultra-sound in production of deep-seated cortical lesions in the basal



Figure 1

Antero-posterior view showing the solid metal stilette (arrows) inside the flexible polyethylene catheter introduced to almost the proper distance approaching the globus pallidus preliminary to alcohol injection.

ganglia. A report from the University of Illinois in April, 1958, has to do with the first clinical use of ultra-sound to produce "therapeutic" brain lesions and relieve tremor and rigidity in 11 patients with Parkinson's disease and one with cerebral palsy and athetosis, reported by a team of physicians from the University of Illinois and State University of Iowa, including Dr. William Fry and Dr. Russell Meyers. Preliminary results obtained by focusing four ultra-sound cones simultaneously on two brain structures, the ansa lenticularis and the substantia nigra, for two to three seconds, were very encouraging—relief of tremor and rigidity, with no untoward effects, according to these physicians. This is the first time, according to Dr. Fry, an ultrasonics expert, that any lesions have been produced in the substantia nigra alone with resultant relief of tremor and rigidity in Parkinson's disease. These workers found it unnecessary to produce lesions in the globus pallidus in order to selectively obtain symptomatic relief. The

lesions are created under local anesthesia after craniotomy to permit entrance of the ultra-sonic beam into the brain tissues.

With reference to the newer, more critical criteria for selection of patients with Parkinson's disease for chemopallidectomy, Fairman and Cooper⁵ have recently stated as follows: The operation, in order to be successful, should not only relieve the rigidity and tremor, but also furnish the patient with the help needed to become a wage earner again and to overcome incapacitation generally. The most important contraindications are: pseudo-bulbar symptoms, mental deterioration, vegetative signs, spontaneous hyperthermia and excessive sweating and salivation, respiratory difficulties such as uncontrollable hyperpnoea, and psychiatric disorders. Physiologic signs of senility also contraindicate surgery, but chronologic aging, *per se*, does not. Parkinsonian patients with unilateral or bilateral symptoms and none of the foregoing contraindications are potentially good candidates for chemopallidectomy provided definite progression of the disease, failure of medical therapy, and a marked degree of involvement justify this course of action. We fully believe



Figure 2

Lateral view of the same technique. The metal stilette (arrows) which is a rigid structure, has not been introduced quite far enough as shown by the fact that it is still slightly above the foramen of Monro.

that most patients over 60 - 62, especially those in wheel chairs or bedridden with over-salivation or other symptoms listed above, should

not be operated on in the present state of our knowledge and experience. Almost all writers today agree that the ideal candidate for the operation is under 60 years of age, preferably with only one side grossly involved, with poor response to medication, still ambulatory and in good general condition, but with diminished earning power. If the operation is restricted to this group, a very high percentage of long-lasting cures or gratifying alleviation of symptoms is to be expected.

McKinney's pallidotomy leukotome technique: W. W. McKinney of Fort Worth, Texas, has recently devised a pallidotomy knife, or leukotome, which is utilized much as is Cooper's chemopallidectomy except that the small knife is used instead of the polyethylene catheter and alcohol injection. It was

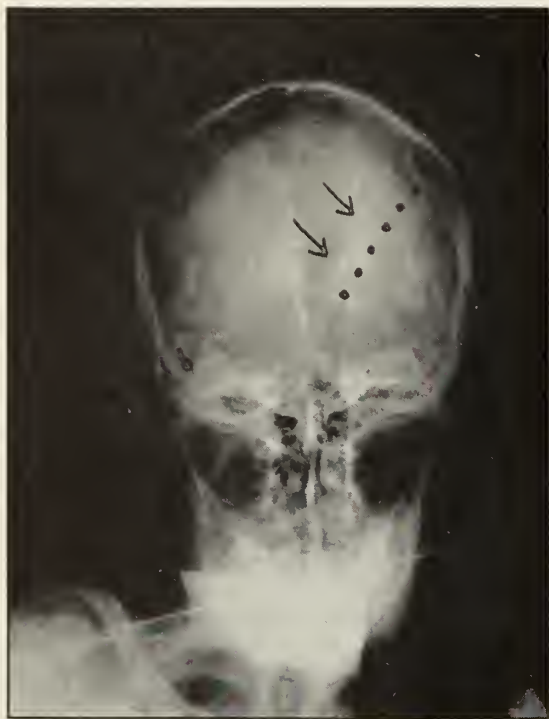


Figure 3

Antero-posterior view showing (arrows) the flexible polyethylene catheter now in satisfactory place for injection of alcohol into the globus pallidus. The catheter has been retouched to emphasize its position in the subcortical location.

developed for the purpose of producing a lesion in the globus pallidus or in any other portion of the brain, such as the ventrolateral nucleus of the thalamus. It is designed so that an area 1 cm. in diameter can be destroyed by



Figure 4

Lateral view. The lowest indelible marker is now in position, (arrows) slightly above the sella, and posterior to the foramen of Monro where experience has shown is the optimum location for injection of the destructive agent (alcohol) in the globus pallidus or thalamus; (slightly retouched for clarity.)

cutting or by using an electrocoagulation technique. The instrument can also be used for stimulation of subcortical structures. The operative technique carried out in the use of the pallidotomy needle of McKinney (who has used this method now in more than 100 cases with no untoward effects, such as serious bleeding or other complications) for use in Parkinson's disease is very similar to the technique used by I. S. Cooper with chemopallidectomy.

Summary, with reference to our preferred operative procedure today. Considering all the technical procedures mentioned above that are now utilized and available for the relief of this distressing malady, parkinsonism, it might be said that the majority opinion today in neurosurgical clinics (in this country at least) favors either (1) chemopallidectomy by means of alcohol injection into the basal ganglia, or (2) the pallidotomy knife-cutting technique of McKinney. Ultrasound techniques that are utilized now in some of the research centers, such as the University of Illinois and the Massachusetts General Hospital, are so elaborate and time-consuming that they are certainly not very practical and feasible for most hospitals at the present time in which parkinsonism patients are being operated upon. The operative procedures

utilizing this latter technique are quite long—from eight to ten hours in length—and the equipment is extremely costly and elaborate; only a very few operations to date have been performed in human subjects with ultrasound. Stereotaxy machines are also quite elaborate and although used as a valuable research tool in certain neurophysiology laboratories and a few hospitals throughout the country, are not in great favor in the general hospitals of this country at this time for surgical procedures. It is our firm impression today therefore, that with the restrictions in selection of the patient already mentioned (the importance of which cannot be overemphasized), and the careful meticulous use of either (1) chemopallidectomy technique using alcohol, or (2) McKinney's subcortical pallidotomy knife cutting procedure, one can obtain the best overall and long-standing results in the surgical attack upon this distressing disease.

Conclusions: Surgical techniques are available which, if carefully executed in the proper cases, can produce good results in approximately 60 to 70 percent of patients with parkinsonism chosen for operation. Statistical-

ly, therefore, there is as much if not more justification for neurosurgical treatment of parkinsonism as there is for neurosurgical treatment of intractable pain, focal epilepsy, and other diseases which merit the serious attention of neurosurgeons, as emphasized by Cooper. Much remains to be learned about the surgical attack on parkinsonism and undoubtedly technical improvements will be forthcoming. The general practitioners who presently carry the burden of primarily caring for the large population of parkinsonism patients should now consider *neurosurgical intervention* as one possibility in the treatment of *selected* cases among the *moderately advanced patients*. The neurologists can consider the fact that neurosurgery has satisfactorily relieved patients for three years and longer, in many cases. Not only should this provide increased impetus to produce more satisfactory medical therapy, but it should also impose a challenge to interpret the new clinical material which will be forthcoming from more widespread surgical investigation of the basal ganglia in different clinics in this country and abroad.

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FIBROCYSTIC DISEASE A REVIEW

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Fibrocytic disease has a rather interesting history. It was first classed as one of the diseases in the celiac syndrome because of the clinical picture of emaciation and large stools. In 1936 Fanconi and in 1938 Anderson¹ in the United States separated this condition from celiac disease when they found that the pancreatic enzymes were deficient. The name, therefore, was changed to pancreatic fibrocystic disease. In 1944 Farber,² realizing that the lungs were involved in a large number of patients with this syndrome, thought that the mucous secreting glands were involved because of the thick, viscid fluid from these glands which caused obstruction leading to cyst formation and later fibrosis in the lungs. He coined the name mucoviscidosis. Still further advances were made when Anderson, Kessler, and diSant'Agnes in 1951 discovered that the eccrine sweat glands as well as the mucous glands were involved. On analyzing the sweat from patients with fibrocystic disease, they found an abnormally high concentration of sodium, potassium, and chloride to be present. Also recently it has been shown that the parotid secretory rate is greatly increased³ and the liver has also been shown to be involved, in that biliary cirrhosis⁴ has also developed in these patients.

Because of the later findings mucoviscidosis is no longer an acceptable name since certainly other glands are involved. The name of generalized *exocrinopathy* has been suggested but it has been requested by those interested in this disease that the name not be changed at present until the etiology of the disease is clarified, and for this reason "fibrocystic disease" is the preferred term at present, although admittedly this is inadequate.

This disease is quite rare in Negroes and has shown the incidence of one in 600 live births and 1.7 per thousand live births in two studies.^{5,6} Males and females are equally

affected. The disease may be present in partial forms, with one system showing more extensive involvement and the others less involvement. Twenty per cent of parents and siblings of patients with fibrocystic disease showed an increased concentration of sweat electrolytes. The pancreatic function in these relatives was normal, but the occasional chronic lung infection encountered suggested that these relatives probably had incomplete forms of the disease. Geneticists believe that there is present a recessive gene or genes which may cause the disease in homozygotes and partial or no expression in heterozygotes.³

Pathogenesis

The pathogenesis of this disease includes involvement of the various organs mentioned above. The pathologic picture of the pancreas in this condition shows eosinophilic concretions which obstruct the ducts and cause dilatation of the acini and degeneration of the parenchyma with fibrosis. The viscosity of the pancreatic secretion is increased and the pH has been shown to be more acid. There is a deficiency of the enzymes lipase, amylase, and trypsin. Deficiency in lipase results in large, greasy, foul stools which are never watery. The fats are not split and therefore, large amounts of neutral fats are present in the stools, with resulting loss of the fat-soluble vitamins A, D, and K. Calcium also tends to be absorbed less well since it combines with the fats to form soaps and is lost in the stools. The deficiency of amylase prevents the splitting of starches, which are larger, more complex carbohydrates, and these are therefore present in the stools. The simple carbohydrates, the monosaccharides and disaccharides are absorbed without processing and therefore total carbohydrate metabolism is not greatly impaired. Because of the deficient excretion of the enzyme trypsin, protein is not utilized and is lost in the stools in large amounts. However, large amounts given in the diet will increase the total amount absorbed.

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TABLE 1			
<i>Duodenal Fluid in Pancreatic Insufficiency</i> ⁷			
Test	Controls	Complete	Partial
Vol., ml/hr	8-25	1-10	5-25
pH	6.0-8.4	3.5-8.1	5.0-8.4
Bile	20-125	10-125	10-125
Viscosity-time, min.	below 3	over 3	over 3
Amylase, units	4-20	0-1	0-20
Lipase, units	3-10	0-1	0-10
Protease, units	18-70	0-2.5	0-70
Carboxypeptidase	0.40-1.00	0-0.40	0.00-1.00
Chymotrypsin	11-65	0-5	0-65

The clinical manifestations of the deficiency of the pancreatic enzymes and the differences noted in the duodenal fluid as shown in Table 1 result in malnutrition with the characteristic large stools. Vitamin deficiency, of the fat soluble vitamins especially, might be noted as well as a deficiency of calcium. Meconium ileus in the newborn period is found in about 10 per cent of the patients who develop fibrocystic disease and presents the picture of intestinal obstruction with possible rupture and peritonitis. Pancreatic enzymes are produced in utero and some authors⁸ suggest that they may be more active during the last month of gestation. The function of trypsin in utero and in the immediate newborn period is to digest and liquify the meconium. When this enzyme is absent or deficient the meconium is quite thick and viscid and thereby cannot be readily passed with peristaltic action. This meconium contains abnormal protein which can be precipitated with 20 per cent trichloroacetic acid. This protein cannot be precipitated from normal meconium. This test is useful in differentiating between atresia and meconium ileus at the time of operation.

Liver involvement takes place in several stages. The first stage of involvement is that of biliary cirrhosis, with concretions of eosinophilic material plugging the bile ducts similar to the pancreatic concretions. In both of these organs this state is thought to be due to inspissated secretions. The second stage of liver involvement results in multilobular biliary cirrhosis with concretions, and an extension of the fibrosis with resulting atrophy of the liver parenchyma. Irregular nodules may be palpable because of the focal character of the initial lesions. Only moderate biliary stasis is present if there is any. Clinically, with early involvement of the liver, there are no symp-

toms or laboratory findings present because there is enough normal liver left for adequate function. Usually the liver involvement is recognized through the signs of portal hypertension. The liver is found to be large, hard, and the typical signs of portal hypertension with hepatosplenomegaly, hypersplenism, and gastrointestinal bleeding are present. The liver function studies may be abnormal at this time but are not invariably so. The bilirubin is usually normal and there is no clinical jaundice present. About 22 per cent of the patients with fibrocystic disease have been shown at autopsy to have cirrhosis of the liver, and about 2 per cent of the patients with fibrocystic disease have clinical evidence of portal hypertension.⁴

The pathologic process in the lungs is primarily that of bronchial obstruction. It is felt that acute respiratory infections start the cycle by causing an increased secretion of mucus which is thick and tenacious. Failure to remove this mucus leads to wide-spread bronchial obstruction which predisposes to secondary infection. The mucus has been analyzed in patients with fibrocystic disease and there is no significant difference chemically between this mucus and that of normal patients. Tissue stains for mucopolysaccharides showed that only one type of stain gave a difference from the controls, which is suggestive of a bond more easily broken by an oxidizing agent, but it may be that the protein portion will prove to be abnormal. The mucus has been shown to be slightly more resistant to trypsin digestion than normal and may contain more numerous weakly acid groups. The mucus present in the duodenal fluid of normal patients when precipitated can normally be readily redissolved in water, however, in patients with fibrocystic disease when this precipitate is formed, a considerable portion is not redissolved in water nor with trypsin.³ There may be many enzymes which are involved in the abnormal mucus formation, if indeed the mucus formation is abnormal in these patients.

A variable degree of bronchial and pulmonary involvement is almost a constant feature of this disease and the clinical course and prognosis usually depends on the extent of the involvement. This involvement usually occurs

between the ages of six months and two years and it is the pulmonary manifestations which account for 90 per cent of the deaths in patients with fibrocystic disease. A patient with pulmonary involvement of fibrocystic disease shows eventually a typical barrel shaped chest which is tympanitic and shows scattered rales throughout. Clubbing of the fingers and toes also results. Respiratory distress of varying degree with generalized pulmonary infection is a prominent feature of the lung involvement, and this distress is frequently quite severe, with air hunger and cyanosis present. Obstructive emphysema due to the ball-valve effect of the tenacious mucus results in limitation of respiratory excursions, poor alveolar aeration, anoxia, and CO₂ retention. Mediastinal and subcutaneous emphysema may be massive and spontaneous.⁵

Because of the high pressure in the pulmonary vasculature with the chronic pulmonary disease, particularly when acute infection is superimposed, rapid cardiac dilatation with circulatory embarrassment and cor pulmonale may occur. Because of the intact myocardium this may rapidly return to normal if the infection is overcome. Evidence of cardiac failure is a sign that the lungs have lost their elasticity and that the pulmonary hypertension is severe. For this reason there is only limited effectiveness of digitalis, diuretics, etc. when heart failure is present. One third of the patients who die show evidence of congestive heart failure at some time during their clinical course. Asphyxia may be a cause of sudden death in fibrocystic disease when large amounts of thick tenacious mucus are suddenly mobilized by coughing and the patient, being unable to clear the airway, dies as a result. Infection with rubeola and pertussis may initiate the chronic bronchopneumonia which these patients show, and these patients should therefore be protected from these diseases as far as possible. Other contagious diseases cause no particular complications.⁹

The sweat glands form a very interesting part of the pathogenesis of this disease. These glands are divided into two general groups: the apocrine glands which are present in the axilla and the perianal region, and the eccrine

glands which are present over most of the body. The number of the eccrine glands varies from a large number on the back of the hand to a smaller number present on the anterior part of the chest. Two types of stimuli may cause sweating in the eccrine glands. Thermal sweating is produced on the trunk, extremities, and head. Psychic or emotional stimuli produce sweating of the palms, soles, and axilla. The rate of sweating is not abnormal in patients with fibrocystic disease. It was found that the sodium and chloride concentrations were increased in fibrocystic disease to 2 to 5 times the normal level and that the potassium was also increased to a small degree.

TABLE 2
Analysis of Sweat In Fibrocystic Disease³

	Controls	Fibrocystic
Volume (ml/M ² /hr)	144	152
Urea mg. per 100 ml.	1.78	1.81
Chloride mEq/L	4-60	60-160
Sodium mEq/L	10-90	80-190

As can be noted in table 2³ there is a minimal overlap in the normal values and those in fibrocystic disease. Metabolic studies in fibrocystic patients showed that the increased concentration of electrolytes was not a result of impaired adrenal or kidney function and was not affected by the administration of DOCA, by increased salt in the diet or by exposure to high temperatures for a prolonged period. It was also found that other patients with chronic lung disease, acquired pancreatic deficiency states, cirrhosis of the liver, and diabetes mellitus did not have abnormal sweat electrolytes. Other causes of increased electrolytes in the sweat are hypoadrenalism, increased rectal and skin temperature, a vapor barrier, arterial occlusion, and an increased rate of sweating with prolonged sweating. However, none of these factors accounts for the high level found in patients with fibrocystic disease and it is determined, therefore, that the defect is in the sweat glands themselves.

Only one patient of a group of 140 with fibrocystic disease was found to have normal sweat electrolytes. All of the others had levels 2 to 5 times the normal range. The clinical application of the involvement of the sweat glands is important since these patients are very susceptible to hot weather. A massive loss of sodium and chloride in sweat with relatively

less loss of water will result in salt depletion with vomiting, dehydration, and rapidly progress to circulatory collapse and death. These patients do not exhibit muscular cramps which the normal patients with heat prostration would demonstrate.

The salivary glands have also been shown to be involved in that the parotid secretory rate is markedly increased. However, there is no clear cut difference in the electrolyte concentrations in the parotid secretions from normal patients and from those with fibrocystic disease.

Laboratory Data

Various tests for diagnosis have been used during the evolution of knowledge of this disease. Some of the more useful and practical ones will be discussed briefly.

Tests for trypsin activity were among those found useful in diagnosing this condition. A test for trypsin activity in the stool has been used and is useful as a screening test only, but has the advantage of simplicity. Since bacteria in the stool interfere with the test, giving a false positive test, the stool must be diluted to reduce this bacterial digestion of the gelatin. Lack of digestion of x-ray film by the stool at 1:100 dilution is suggestive evidence of fibrocystic disease. A second test for trypsin activity is that done on duodenal secretions. A tube is passed under fluoroscopy into the duodenum. The secretions are then tested for acidity. However, this testing for acidity is not completely reliable since in fibrocystic disease these secretions are more acid than those normally found in the duodenum and little difference has been shown in the samples containing some stomach acid. Following the placing of the tube, a stimulus for pancreatic secretion is given by means of olive oil instilled through the tube and the fluid is then tested in serial dilutions with a gelatin substrate and the liquifaction of the gelatin determined. Decreased or absent trypsin activity would of course show little digestion or little liquifaction of the gelatin in the lower dilutions.

A test for lipase has been developed and also is useful only as a screening test. This test involves the ability of lipase to split iodine from lipiodol compound. If this enzyme is de-

ficient the iodine is not split off and therefore, is not absorbed. Iodine absorbed from the gastrointestinal tract would normally be excreted in the urine. The test consists of testing the urine for iodine initially, then giving lipiodol orally, and checking the urine at 12 and 18 hours for iodine. No iodine will be excreted if lipase is deficient.

The most accurate of all the tests devised to date for fibrocystic disease is the determination of the concentration of electrolytes in the sweat. Sweat is collected from the anterior chest wall or from the back, on a gauze square which has previously been weighed. This square is covered with a piece of plastic sheeting and the edges are sealed. The patient is then subjected to a thermal stimulus for one hour, the gauze square is removed and the sweat is analyzed for sodium and chloride, after the square is weighed, the sweat is dissolved, etc. The thermal stimulus may be accomplished in older patients by enclosing them completely in a large plastic bag and in small infants by placing them in an incubator at 95° F. for an hour. These patients, particularly infants should be watched closely during the test, because with a large loss of sodium and chloride from the sweat they may show evidence of rapid salt depletion. This is by far the best test available to date. There has been only one negative test reported in 140 patients with fibrocystic disease.³ A simpler method for producing the sweating has been suggested in which a parasympathomimetic drug is injected intradermally and the sweat collected as above. The material used in the series studied, which gave comparable results to the thermally induced sweating, was Furmethide, but this drug is no longer being manufactured and bethanechol chloride (Urecholine) 0.5 mg. has been tried. The amount of sweat produced with this latter drug was not as great but in most cases was considered satisfactory.¹⁰

A test has been suggested for the determination of sodium and chloride in the saliva, but this test has not been shown to be reliable. While there is an increase in the sodium and chloride excreted in the mixed saliva, there is considerably more overlap in normal persons and patients with fibrocystic disease.

Recently another useful screening test has been devised by Shwachman which is a test for the determination of the amount of chloride on the palms or soles. A medium is prepared with agar, silver nitrate, and potassium chromate and is poured into petri dishes. The chloride from the palm on contact with the medium forms a precipitate and results in a white handprint. Only a faint print is present with a normal subject and a definite white print is present in patients with fibrocystic disease. This test must be standardized to some extent by having the patient wash and dry the hands thoroughly one half hour before since the duration of sweating, the amount of sweating, etc. would tend to influence the results rather markedly.¹¹

Roentgenographic findings are often diagnostic of this disease. In patients with meconium ileus in the newborn period,



Figure 1

Meconium Peritonitis

5 day old infant showing air under diaphragm, calcifications in peritoneal cavity (right upper quadrant) and small caliber of large bowel, following barium enema.

roentgenograms show the usual picture of obstruction, usually in the region of the small bowel, and if a barium enema is given, the colon appears small, but this latter is thought to be due to lack of distention from meconium. Calcifications have also been described in the meconium present and in the intestinal wall. Meconium peritonitis shows again characteristic findings on roentgenograms. Free air is frequently detectable on a flat film of the abdomen and fluid is also seen to be present in the peritoneal cavity. Calcifications are present in the meconium in the peritoneal cavity and these have been noted to occur within 24 hours of the perforation.¹² (Fig. 1.)

Roentgenograms of the lungs can be quite characteristic in fibrocystic disease. There is an increase in anteroposterior diameter, the diaphragm is flattened and the heart appears small. Obstructive emphysema of a generalized nature is noted and this is frequently of a ball-valve type. (Fig. 2.) Widespread

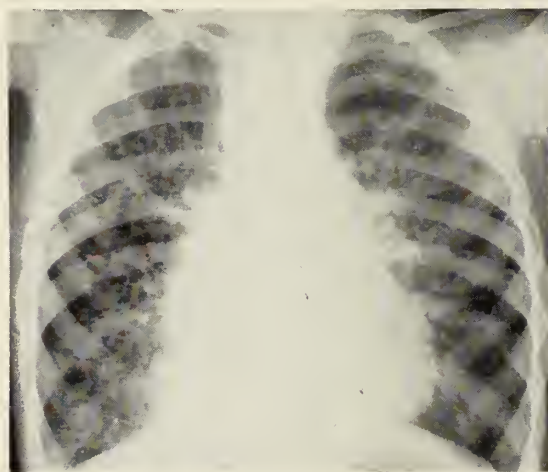


Figure 2A

Emphysema with flattening of diaphragm, widened intercostal spaces, "barrel chest" and patchy areas of fibrosis.

chronic bronchopneumonia is a characteristic finding in the lungs on x-ray examination and is proportional to the duration of the disease. There is a honeycomb appearance early and in more advanced cases, a snowflake appearance to the lungs. Abscesses may form later. (Fig. 3.) The organism frequently found in secondary lung infections in fibrocystic disease is *staphylococcus aureus* and this tends

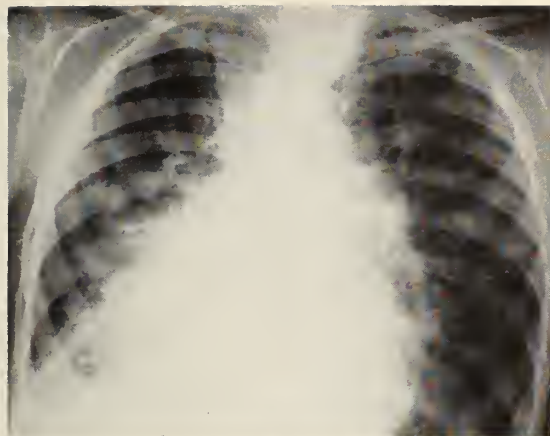


Figure 2B

5 days later showed increase in bronchopneumonia.

to give a fairly characteristic x-ray picture in itself with the formation of abscesses, cysts, etc. Lobar atelectasis is another characteristic finding on the x-ray examination of patients with fibrocystic disease and 10 per cent of the cases are reported as having this with the first pulmonary involvement. The right upper lobe is most frequently involved and then others, usually on the right. This is probably on the basis of an aspiration mechanism.⁹

Treatment

The treatment of this disease would obviously vary with the degree of involvement of the various systems. Pancreatic enzymes should be supplied if there is evidence of deficiency of the pancreatic secretions. They are usually given in the form of pancreatin 5 grams 3 times daily with meals. With the use of these enzymes the digestion improves, the nutritional state returns to normal, and stools

are also improved. Also a positive nitrogen balance can be established and there is an increase in fat absorption.¹³ Water soluble vitamins should probably be given in preference to the fat soluble form. The treatment of meconium ileus is surgical with removal of the meconium and usually the instillation of trypsin alone or in combination with the other pancreatic enzymes in order to liquify the meconium.

The lung involvement occurring with fibrocystic disease cannot be attacked so directly as can the deficiency in pancreatic enzymes and treatment is largely symptomatic. With the advent of antibiotics there has been a definite difference in the survival time of patients with lung involvement in fibrocystic disease. Large doses of antibiotics are necessary and should be given while there is any evidence of infection by clinical or laboratory data. This usually involves months or years of oral antibiotic therapy. In advanced disease a barrier between the alveolar walls and the blood stream apparently develops so that antibiotics given systemically do not reach the alveoli in high concentration. In such cases aerosol therapy with antibiotics and bronchodilators is sometimes helpful and at times trypsin may be used to liquify secretions. This latter is irritating, however, and should be reserved only for extremely severe involvement. The aerosol therapy is usually given for 20 minutes three times a day and is followed with postural drainage. In advanced disease an intermittent positive pressure breathing machine may be helpful when the emphysematous state is present. Bronchoscopy is contraindicated in these patients since it has been shown to be ineffective in causing any satisfactory response. A lobectomy for atelectasis of a lobe occasionally is indicated if the atelectasis has been localized for more than six months, if no more than two lobes are involved and the other lung is free of infection. However frequently this fails to modify the general downhill course in these patients.⁹

Increasing the productiveness of cough in patients with fibrocystic disease is good symptomatic therapy and postural drainage is frequently quite beneficial if the patient is not having severe enough respiratory difficulty so



Figure 3

Widespread bronchopneumonia with "snowflake" appearance.

that he can tolerate some slight further reduction of his vital capacity during the period of drainage. The development of respiratory acidosis must be kept in mind in patients with pulmonary involvement due to fibrocystic disease. Hypoventilation with a decreased alveolar ventilation occurs with increase in intrathoracic pressure and also with obstruction as another possible cause. Depression of the respiratory center occurs with respiratory acidosis and the patients breathe mainly on the stimulus of anoxia. If they are given oxygen this stimulus may be removed. However, clinically, adverse effects are not seen but one should be aware of this potential danger in administering oxygen to these patients although it is not recommended that it be withheld generally. If heart failure should occur digitalis should be used for a brief period only. When portal hypertension or hypersplenism is present the treatment again is surgical and a shunt procedure is usually done and good results are frequently obtained.

Because of the sweat gland abnormality, acute electrolyte loss occurs in hot weather in patients with fibrocystic disease.³ This is, in effect, a pure salt depletion with a rapid loss of sodium and chloride from the extracellular fluid compartment while the intracellular fluid compartment remains relatively normal. The circulatory changes which occur in this condition are more severe than those encountered in pure water depletion. The effect of pure salt depletion is quite similar to the shock which follows extensive burns, severe trauma, or hemorrhage. The serum chloride is found to be quite low, the serum sodium quite low, while the serum CO₂ is normal. Usually the concentration of electrolytes in the sweat decreases as the serum level decreases. However, in patients with fibrocystic disease there is a complete dissociation of this mechanism and sodium and chloride continue to be lost from

the sweat in high concentrations even though the serum levels may have reached quite low points. This condition should be suspected when patients with fibrocystic disease have vomiting and dehydration during hot weather. Hyperpyrexia, circulatory collapse, and coma follow in rapid succession. Death will ensue if this acute medical emergency is not treated promptly and vigorously to achieve restoration of sodium, chloride and water. The treatment is physiologic saline intravenously since this is urgently needed by these patients. Prophylactically it may be advisable to increase the sodium chloride intake in patients with fibrocystic disease during hot weather and particularly should the parents be warned of the possible danger which these patients may encounter when exposed to high temperatures.

Prognosis

The overall prognosis in patients with fibrocystic disease depends on the completeness of the picture in the individual patient and the extent of involvement of the various systems, particularly the lungs and liver. The lung involvement is probably least effectively treated at present and accounts for 90 per cent of the deaths. There is a partial therapeutic effect of antibiotics on patients with this pulmonary involvement which has been shown to be the commonest cause of chronic non-tuberculous lung disease in the pediatric age. Secondary infection in the lungs may cause irreversible damage. However, if these patients reach late childhood without irreversible lung damage the findings may clear remarkably both clinically and on x-ray examination. Many of them are left in adult life with chronic pulmonary disease.⁶

Summary

A review of the evolution of the knowledge of fibrocystic disease has been presented. The pathogenesis and treatment of the various aspects of the disease have been discussed.

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RESISTANT STAPHYLOCOCCIC ENDOCARDITIS CURED WITH NOVOBIOCIN

A CASE REPORT
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Novobiocin is a relatively new antibiotic which is produced from two streptomyces organisms producing a single identical drug.^{1, 2} They are marketed as Albamycin[®] and Cathomycin.[®] This drug is also apparently identical with Cardelmycin.[®]³ It has been found to be quite effective against staphylococci and there is a very extensive bibliography available in regard to all phases of its use. The present case is of interest in that a patient with bacterial endocarditis was cured after apparent failure with other antibiotics.

Case Report: An 18-year old, colored, married female was admitted to the Rheumatic Fever Service of the Columbia Hospital on September 3, 1956 because of chills, fever, and pain in the fingers and toes, headache and cardiovascular abnormalities. The patient apparently had rheumatic fever in 1950, but details of the illness are lacking. Two years prior to admission she delivered a normal child without showing any signs of congestive heart failure or other abnormalities. One month prior to admission a tooth was extracted and one week following this extraction she began having severe headaches, chills, fever, and pain in her fingers and toes. Roughly seven days after the onset of this illness she aborted spontaneously a 2½ months fetus. Her chills, fever and illness continued, however, in spite of penicillin therapy and she was admitted for further treatment and care.

The patient was an acutely ill, colored female with

some questionable nuchal rigidity and numerous splinter hemorrhages in the nailbeds. Petechiae were scattered over the conjunctiva and mucous membranes, as well as the skin. The blood pressure was 140/50 and examination of the heart showed slight enlargement and a loud, regurgitant, diastolic decrescendo-type murmur heard over the entire precordium, loudest at the base. A definite systolic murmur and a thrill were also present in this area. At times the murmur was thought to be loudest in the pulmonic rather than the aortic areas. The spleen was not palpable and there were no findings to suggest congestive heart failure.

Shortly after admission a single blood culture was obtained and the patient was started on penicillin prior to being seen by this observer. Eight subsequent blood cultures were obtained after the administration of penicillin which were all negative. Initial blood culture, however, subsequently grew hemolytic *Staphylococcus aureus*, coagulase negative. Hemoglobin was 7.5 gm. per 100 ml. on admission and remained low throughout the illness in spite of transfusions. White blood count was 16,300 on admission with 87% segmented forms, 2% eosinophiles, 10% lymphocytes and one per cent monocytes. Serial white blood counts ranged between 16,000 and 6,000, and at no time was there any granulocytopenia. Urinalyses showed varying amounts of albumin which cleared towards the end of the hospital stay. On October 20, 1956 total bilirubin was 1.25 mg. with .25 direct bilirubin. Icterus index was 17 and 20 units, respectively, on two occasions.

Roentgenograms of the chest showed marked cardiac enlargement, more to the left than to the right, without significant vascular changes or decrease in heart size throughout the hospital stay. Serial

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electrocardiograms first showed evidence to suggest myocarditis and later tracings suggesting either increasing left ventricular hypertrophy or myocarditis. No evidence of right ventricular hypertrophy was noted.

The patient's temperature, on admission, was 104° F. and she was started on penicillin, one million units intramuscularly every four hours. At the end of four days there apparently was no response to this medication and novobiocin (Albamycin) 500 mg. every 4 hours was given orally in addition to the penicillin, which was increased to one million units every two hours. On the 9th hospital day, or five days after this regime had started, the patient's temperature began to fall toward normal, but after 48 hours of apparent response, began to rise again. At this time penicillin was discontinued and erythromycin (Ilotycin) 200 mg. every 4 hours was given in conjunction with the Albamycin. The patient's temperature continued to rise in spite of these two medications, and on the 14th hospital day the patient was seen to be critically ill. These two drugs were therefore discontinued and the patient was started for the first time on probenecid (Benamid) 0.5 gm. every six hours and aqueous penicillin, five million units every four hours. On this regimen the patient seemed to respond initially with a gradual fall of temperature toward normal, but at the end of one week of this therapy, temperature had risen again to 105° F. and a severe, almost exfoliative skin rash had developed. In spite of the rash the medication was continued until September 26, 1956 at which time it was discontinued when intravenous novobiocin was first made available to us.⁶ The patient was given Albamycin 500 mg. intravenously on September 27, but because of the difficulty of administering the medication by vein, on the following day intramuscular Albamycin was given every 12 hours in the amount of 500 mg. This was continued without interruption for seven days, during which time the patient showed marked improvement: the rash cleared and temperature fell gradually to levels between 100° F. and 101° F. orally. At the end of this time novobiocin for intramuscular use was no longer available and the patient was started on novobiocin orally, one gram every four hours. This was tolerated well for the first four to five days, until some nausea developed. This was well controlled by the use of chlorpromazine (Thorazine), 25 mg. by mouth, one-half hour prior to each dose of novobiocin. This medication was continued at this level for 36 days without further signs of toxicity, skin rash, or other difficulty. Icterus index was slightly elevated, but this was felt to be due to the pigment in the drug, rather than actual liver damage, although cephalin flocculation was ++ after approximately 15 days of administration of this drug.

After discharge from the hospital the patient has continued to do well in regard to bacterial recurrence.

⁶Through the courtesy of Dr. J. A. Dugger of The Upjohn Company.

She shows signs of considerable valvular deformity and careful study, including cardiac catheterization at another institution, has shown no evidence of pulmonary valvular disease, in spite of the seeming loudness of the murmur in this area.

Discussion: This case presents several interesting facets. The patient presented a staphylococcal septicemia which subsequently proved to be resistant to extremely large doses of penicillin and also moderate doses of novobiocin, as well as erythromycin, by mouth. In spite of previous treatment with novobiocin, the patient did respond to large doses of this medication parenterally and maintained this response to extremely large oral dosages (6 grams daily) without evidence of any significant toxicity from the drug.

Novobiocin is known to develop resistance fairly rapidly in a step-like fashion *in vitro*.^{3, 4, 11, 13} and response *in vivo* after previous treatment is noteworthy. The medication was given in conjunction with other antibiotics and no synergism could be detected clinically when used with penicillin and later with erythromycin.^{4, 5} As our patient did not receive chloramphenicol, no comparison with this medication can be made.⁵

The number of cured cases of bacterial endocarditis is relatively small when organisms other than *Streptococcus viridans* and medications other than penicillin and streptomycin are used.^{6, 7} This patient is definitely cured as she has been followed well over a year without recurrence. This suggests that the medication in high dosages may be bacteriocidal rather than bacteriostatic.⁴ Our patient received, following the parenteral therapy, three times the usual dose, which may have contributed to the eradication of any residual focus of infection.

This patient actually had a severe skin rash prior to the institution of intravenous novobiocin, presumably due to penicillin, which actually cleared during the administration of novobiocin and no further rash occurred. The presence of skin sensitivities and rashes is apparently a significant limiting factor in the use of this medication, but fortunately did not appear in this case. Neither did any evidence of agranulocytosis or granulocytopenia occur, in spite of prolonged and intensive therapy. The presence of a slightly elevated icterus index in this patient was felt to be due to a pigment known to be present in this medication and perhaps did not concern us enough in view of the slightly positive cephalin flocculation test.¹⁴ She, however, showed no other signs to suggest decreased liver function, and continued to show symptomatic improvement throughout this entire period of time. It is also of interest that at no time did the patient develop any diarrhea or gastrointestinal symptoms, in spite of the extremely high dosages of medication which were used. Toxic reactions are a serious problem with the drug, occurring in as high as 18.7% of cases,^{8, 9, 12} and death has been reported.¹⁰

Summary: A patient is presented in whom staphylococcal endocarditis resistant to large doses of penicillin and moderate doses of novobiocin and erythromycin by mouth was treated with large doses of novobiocin intravenously and extremely large doses of novobiocin orally with resulting cure. No signs of toxicity occurred from the use of this drug in spite of prolonged medication.

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MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Hypothyroidism

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Case Record—Anemia which failed to respond to the usual measures of treatment was the presenting complaint of a 39 year old nurse. At one time she had been treated for hypothyroidism but had taken no thyroid medication for several years. Since then she had gained 15 lbs. in weight and had become aware of dryness of the skin, loss of hair, physical weakness and various gastro-intestinal disturbances.

On examination her skin was pale, dry and scaly, the hair of the scalp and eyebrows sparse and coarse. She did not have the typical "myxedema facies" or demeanor but her voice was somewhat raspy, and the relaxation phase of her Achilles reflexes was prolonged (Woltman's sign).

Laboratory studies revealed a normocytic, normochromic type of anemia with a hemoglobin of 9 grams and hematocrit 34. Blood cholesterol was elevated—266 mg./100 ml. The basal metabolic rate was reported as minus 26.

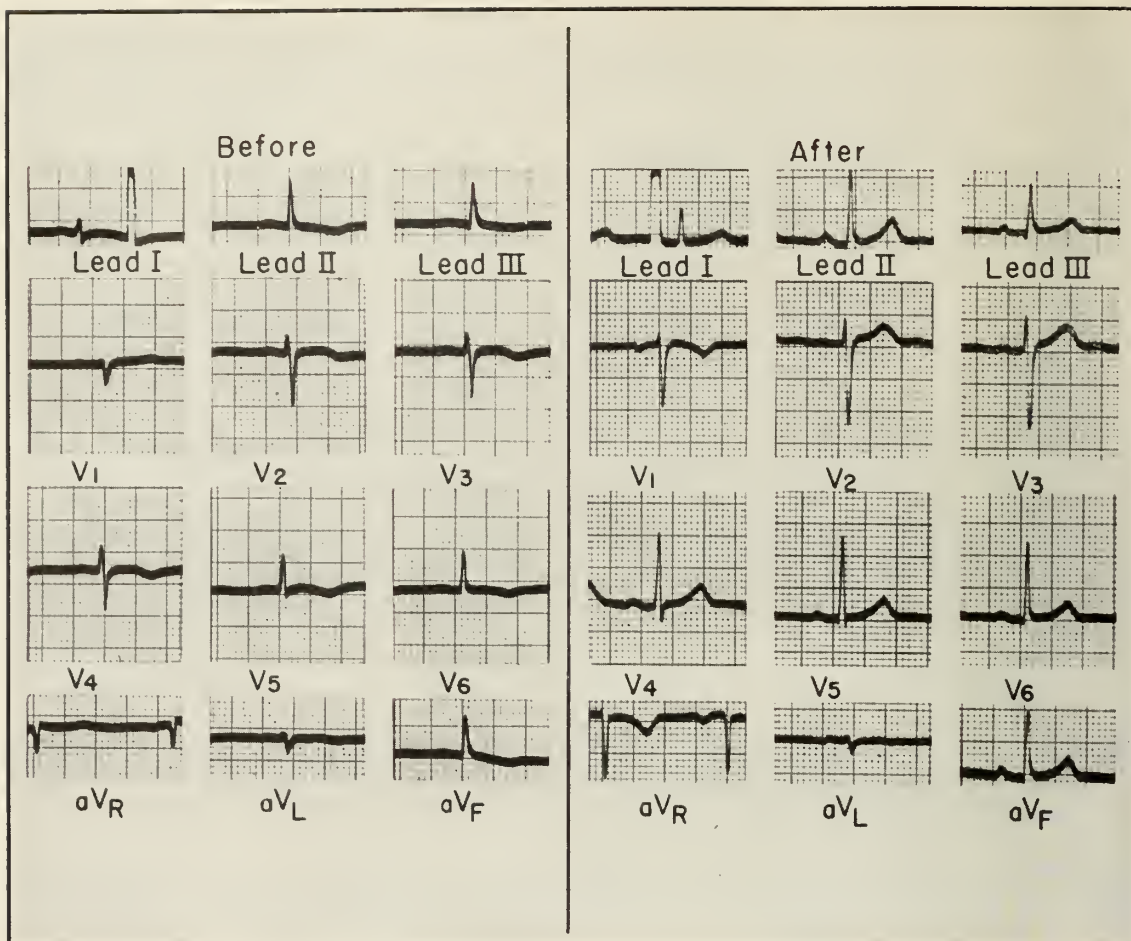
The patient improved remarkably on treatment with desiccated thyroid which was started in a daily dosage of 10 mg. and gradually increased to 100 mg. over a period of 3 months. Her electrocardiograms before and after treatment are illustrated.

Electrocardiogram—A comparison of these two tracings is of much more significance than any single abnormality. Prior to treatment the P waves are almost indistinguishable, voltage of QRS complexes moderately low, the T waves generally flattened or inverted, and the rate (as determined by the R-R interval of 0.88 sec. of aVR) is 68 per minute. For this rate the Q-T interval of 0.44 sec. is abnormally long.

Three months after thyroid therapy was begun the ECG is normal. Voltage of all the complexes has increased strikingly, the T waves are of proper polarity and amplitude, and the Q-T interval has shortened to 0.36 sec.—more than can be accounted for by the increase of heart rate to 77.

The electrical axis is vertical, depolarization being directed toward the left leg and away from the two arms which show predominantly downward QRS deflections.

Discussion—It is almost traditional that electrocardiograms showing low voltage of all complexes and slow



heart rates suggest hypothyroidism. Flattening or inversion of T waves, and perhaps prolongation of the Q-T interval lend additional weight. Although the reversibility of these changes following thyroid therapy is unique, they are in no way pathognomonic of hypothyroidism. Rather, they provide corroborative evidence—and sometimes the initial clue—for this diagnosis.

Apparently hypothyroidism can cause an actual reduction in the electrical potentials generated in the heart. This applies to the potentials of both depolarization and repolarization, in the atria and the ventricles. Conceivably the decrease in voltage may be a manifestation of the general retardation of physiological processes (e.g., of gastrointestinal function, hematopoiesis, cerebration, heat production), but the reasons for a change in polarity of the T waves are less clear. One would expect a uniform diminution of repolarization potentials throughout the myocardium to result simply in lower, flatter T waves—unless the direction of repolarization were altered. Possibly in some cases, such as this one, repolarization is sufficiently delayed (prolonged Q-T interval) to re-

verse its direction. The secondary anemia would seem an unlikely cause. It is of interest that administration of potassium causes some metabolic T wave abnormalities to disappear, though this may entail considerable hazard.

The so-called "myxedema heart" is said to occur in half or more cases of myxedema, especially in middle-aged women, and to be characterized by diffuse cardiac enlargement (the "ham-shaped heart") having poor pulsation of its borders as observed fluoroscopically, decreased cardiac output and bradycardia. The enlargement has been attributed to an edematous infiltration of the myocardium akin to that observed in the subcutaneous tissues. Congestive failure may occur and is notoriously refractory to the usual measures of treatment, as are the cardiac manifestations of hyperthyroidism. An occasional accompaniment is pericardial effusion; this, it should be noted, can itself produce some of the same electrocardiographic abnormalities as myxedema. There is recent evidence that coronary atherosclerosis may be accelerated by the hypercholesterolemia of thyroid deficiency.

From the cardiac standpoint it is highly important to begin thyroid therapy with small doses. The sensitivity to the drug of patients with true myxedema is such that severe palpitation or actual angina or congestive failure may result if the average maintenance dose of 100 mg. or so is given initially. Usual practice is to start with about 10 mg. per day, increasing every week or two by increments of 10 mg. according to the clinical response.

This case illustrates the influence of endocrine function on all complexes of the electrocardiogram.

TUBAL PLASTY

EDWARD J. DENNIS, M. D.

Department of Obstetrics and Gynecology

A 29 year old gravida 1, para 1, was admitted to the Medical College Hospital on April 8, 1958 for tubal reconstruction.

Significant past history indicated that in 1950 she had a spontaneous delivery of a living female infant at term. Her antenatal, intrapartal and postpartal courses were uncomplicated.

In 1951 she was admitted to the hospital for exploratory laparotomy with a preoperative diagnosis of ruptured ectopic gestation. This apparently was not confirmed at surgery, however, at that time, sterilization by tubal ligation was performed for unknown reasons.



FIGURE 1

She was evaluated in June of 1956 as a possible candidate for tubal reconstruction. A hystero-gram taken at that time (Fig. 1) revealed normal size and

configuration of the endometrial cavity but bilateral tubal obstruction at the cornual portion of the uterus, since no dye was seen to enter either fallopian tube.

The patient was first seen in consultation in September of 1957 at which time she was admitted to the Medical College Hospital for evaluation of headaches. Routine pelvic examination was normal. Endometrial biopsy on the patient was reported as showing good secretory or progesterone effect.

Examination of the patient's husband was normal. Sperm count done in February, 1958 showed him to be in the highly fertile category.

The problems of tubal plasty procedures as well as the results predicated on the basis of statistics were discussed in some detail with the patient. She felt that in spite of a poor chance of success, she wished to have the procedure done.

Laparotomy was performed on April 9, 1958 and exploration revealed the uterus to be normal in size and configuration. The proximal two thirds of the right fallopian tube was absent, but there was a normal ovary on the same side. On the left, the fallopian tube appeared to have been ligated 1.5 cm. from the cornu. The ovary was completely normal.

The area of ligation on the left was then excised. The proximal portion of the remaining tube was obstructed since a probe could not be passed into the endometrial cavity. A probe was then passed with ease from the fimbriated end of the left tube to the point of excision, demonstrating 5 to 6 cm. of normal patent fallopian tube. A Weisman borer was then used to make an entry into the uterus just posterior to the obstructed tubal stump. The uterus was then



FIGURE 2

opened transversely across the fundus and tubal mucosa sutured to endometrium under direct visualization. A polyethylene tube was anchored to the peritoneum of the infundibulopelvic ligament with 00000 chromic catgut, the tube having previously been passed through the fallopian tube into the endometrial cavity and out through the cervix into the vagina. Following closure of the abdominal wound, the tube was fixed to the cervix through the vaginal approach with 000 silk. The patient's postoperative course was uncomplicated and she was discharged from the hospital on the sixth postoperative day.

She returned to the office on May 27, seven weeks after the operative procedure, and the polyethylene tube was removed through the vagina after the silk fixation sutures in the cervix had been removed.

On the tenth of June, 1958 a hysterosalpingogram revealed a patent left fallopian tube (Fig. 2).

Discussion: The varied methods of tubal reconstruction presented by different authors attest to the very poor results based on occurrence of conceptions, and even more important, viable infants following such procedures.

It is of interest to contrast the results of a compilation prepared by Greenhill in 1936 with that of a subsequent questionnaire in 1956.

In 1936, the pregnancy rate following surgery was about 6.6% with a 4.4% live birth incidence. In 1956, the pregnancy rate had increased to 19.1% and the live birth rate to 15.1%.

He has admittedly changed his opinion from that of condemnation to one of reserved recommendation, provided the procedure is limited to patients in whom intrinsic disease processes have not destroyed the functional capacity as well as the patency of the fallopian tubes.

Undoubtedly the factors responsible for this improvement in pregnancy rate are first, the development of polyethylene tubing and its utilization in the procedure, and, secondly, meticulous attention to the details of the operation and careful selection of cases.

Summary: A case of tubal occlusion secondary to surgical ligation is presented.

The establishment of patency by reconstruction is demonstrated.

SOCIAL SECURITY FOR PHYSICIANS?

THOMAS PARKER, M. D.
Greenville, S. C.

In the consideration of social security in general, it might be well to start with the premises upon which the social security program is based.

The first is that everyone upon attaining a given age or condition of decrepitude is entitled to federal benefits, primarily money, but possibly other services. As the grasshopper sang, "The world owes me a living". Under certain conditions the benefits may be denied because of excessive residual initiative or failure to comply with technicalities.

The next proposition is that it is right for everyone to be forced to provide these benefits for himself. This, of course, is the authoritarian concept that it is right actively to force people to do something someone else thinks is right, as opposed to the libertarian concept that force should be used only to prevent wrong-doing. One has to use force occasionally to train animals and children, but authoritarians treat adults as children.

Third, the force to be exerted for the provision of these benefits is taxation. It is assumed that this is a fair, democratic and desirable means.

Fourth, it has been asserted that since taxation is used for the provision of the benefits, those being taxed are paying their own way. It is becoming increasingly obvious, however, as Congress changes the law year after year increasing "benefits" and taxes, that the present beneficiaries did not provide that which they receive, but that it is in reality federal largesse, extracted from present taxpayers who will

have to get theirs later from still other and younger taxpayers. For those who receive benefits to provide them for themselves, it is obvious that taxes should be collected before benefits are disbursed and that once a person becomes a beneficiary, his benefits are fixed, because he will never pay any more taxes. In a backhanded though important way, the federal government recognizes that social security payments do not represent earned income, since they are classified as charity and hence tax-exempt.

There are many reasons why doctors should oppose being included in social security. Perhaps the most obvious is that the system is financially unsound. Prior to this year, social security income exceeded outgo, primarily because eligible beneficiaries represented only a small percentage of those included in the system. The majority of those paying taxes were not eligible to receive benefits. This year, however, as more and more people became eligible to receive benefits, payments exceeded receipts. Although taxes are scheduled to rise progressively every few years for some time, there are many who feel that income will never again exceed disbursements for very long, even without the addition of extra benefits by Congress every year or two. Liability for present promised benefits will always exceed the estimated income. And how high can such taxes go? For the self-employed they are presently scheduled to reach 6% by 1975, but in some South American countries now they are 25% of payroll, and in France as much as 35% of payroll.

Bill S. 3508, proposed by Senator Morse, would periodically increase the tax rate so that by 1975 the employee and employer each would be paying 5.5% on a wage base of \$6,000, and self-employed would be paying 8.25%. Certain increased benefits in public assistance are provided and the funds for this increase would come from increased appropriations from general revenues. One should realize that the social security taxes are deducted prior to income taxes and there are no allowances for dependents, etc., so that this is an additional tax on gross income. (JAMA, July 19, 1958, p. 1520).

In addition, there are those equipped to calculate such things who estimate (for social security experience and practice do not permit sound actuarial computation) that the present obligations of the social security system exceed 280 billion dollars—more than the current, nominal national debt. This sum is represented by 20 million dollars in cash—the petty cash account which, with the tax income, keeps the present payments going—and the remainder in government bonds, the actual cash having been transferred to the general treasury funds and spent. This means that when the social security system needs its money for payments, it must endeavor to redeem its bonds, which can only be done by collecting the cash a second time from the taxpayers.

In addition to the above financial consideration, it should be said that in other countries which have provided social security, such as Germany and England, the special taxes counted upon to support the system have proven inadequate and general tax revenues have had to be tapped. But what excess general revenues are available to the United States, currently operating annually billions of dollars in the red, and where shall we find a daft, rich uncle to subsidize our folly for free?

In addition to the disreputable financing described above, it should be realized that social security numbers have no cash surrender value or value as collateral, as conventional insurance policies do—since indeed, as explained, the so-called savings have already been spent, and benefits promised are not guaranteed, but dependent upon the whim of Congress which can change the law any time.

Further discussion of the premise that everyone is entitled eventually to a government subsidy is in order. At least in the world of nature, both amongst animals that operate as individuals and those that are organized into communities, in order to receive, one must produce. (We hope that the consideration of man as an animal is not offensive, but in discussing sociological problems we must use sociological concepts; and in the welfare state we are discussing animal husbandry, with no regard for morals.) By analogy at least, therefore, only individuals who are or who have been productive should receive such benefits—which in turn is the capitalistic concept, as opposed to the welfare state proposal. Nonproducers,

therefore, if they receive benefits, would receive them as charity for moral reasons (again a capitalistic concept), and not as a right.

The proposal that individuals should be forced to provide for themselves is intriguing. One suspects that often the presentation of such schemes as good will toward men is quite the reverse, and is composed of a combination of a desire to do good with someone else's goods (assumption of un-earned power), the unwillingness personally to provide for others, and contempt for the abilities and standards of one's fellow men. Surely all doctors have seen old people who prefer their own squalor to the opulence of institutional residence.

The necessity of forcing everyone to provide for himself is presented as the only alternative to a situation of distress otherwise intolerable. As a matter of fact, there are two traditional alternatives. The first is that the individual should be allowed to do without if he so chooses, like the grasshopper in Aesop's fable. The other is for wealthy philanthropists to alleviate the conditions through endowments, foundations and memorials. It is, of course, true that such charities do not alleviate all the existing distress—but it is also true that they are usually administered in such a way as not to create pauperism and additional need. Of course, for a confirmed socialist, both wealth and philanthropy are as objectionable as economic suffering; indeed they are themselves varieties of economic illness, and should be done away with.

As regards taxation, it should merely be mentioned that all methods of taxation are not fair and equal, and that one must always consider whether the purpose of taxation is to raise money for legitimate governmental functions, or to produce forcible economic change or redistribution of wealth under the guise of legal respectability. Whether the taxpayer is in fact paying his own way, or the way of another, would also seem pertinent.

The rules governing eligibility for social security benefits are so strange and changeable that they will not be discussed here. Suffice it to say that if the benefits are rights provided by taxation, or gifts provided by federal largesse, it hardly seems just to deny them to anyone superficially eligible on grounds of age or decrepitude because of minor technicalities.

The objections to the social security system given above are general and apply to people in all classes of life. There are, however, particular reasons that should cause doctors to wish not to be included. The first is that physicians rarely retire at the age of 65. If they don't, and earn \$1200 per year from their profession, they will receive no benefits until they reach 72—so that the chances of their benefits equaling their payments are poor, given normal life expectancy and fair health. The second is that, barring trick situations such as that of the young physician who became the father of twins eighteen months after he entered the social security system and then dropped

dead, they can obtain better insurance cheaper from private companies, and this coverage, in addition, will have cash surrender and collateral value and a guaranteed eventual payment regardless of the financial success the insured person may have achieved in the meantime.¹ A situation so much more common and probable that it can hardly be called trick is given in the Journal of the South Carolina Medical Association for July 1958: "Social Security says: 'A wife or widow under 62 or the divorced wife of an insured person may receive payments only while she has in her care a child (under 18 years of age) who is entitled to monthly payments.' Thus, many widows who married in their twenties and lost their husbands in their forties, would not receive any survivors' benefits until they reached age 62 because their children would be 18 or older." It cannot be

denied that it is possible for physicians of 63 to enter the system, make payments for 18 months, and then retire and draw lifelong benefits; but surely most physicians are not looking for a chance to defraud their fellow citizens and descendants through legal technicalities.

The final reason for physicians is this. No one can in good faith and with honor seek to obtain federal cash benefits for himself and his family, but oppose on lofty moral grounds the provision of federal medical benefits (socialized medicine), such as are currently proposed in the Forand Bill, for example. No honorable person should exchange his birthright for a mess of pottage.

Thomas Parker, M. D.

1. Webster, R. C. and Coffey, R. L. JAMA: 162:231 (Sept. 15, 1956)

Oxapentamethylenediethylene Thiophosphoramidate (OPSPA) in the Treatment of Human Cancer. Forde A. McIver, A. R. Curreri, Francis R. Russo, Glen S. Hogle, Robert F. Schilling, and Walter H. Jaeschke (Charleston). Ann. New York Acad. of Sc., 68: 1183, 1958.

N-(3-Oxapentamethylene)- N', N'' - diethylene thiophosphoramidate (OPSPA) is an alkylating agent which was synthesized on theoretical grounds based upon previous experience with triethylene melamine (TEM) and triethylene thiophosphoramidate (Thio-TEPA). The present report is a record of the use of OPSPA in 102 patients by persistent therapy (Group I) and in 68 patients by intermittent courses (Group II). Nearly all of the patients selected for study are cases of solid tumors with far advanced disease. Evidence of significant benefit is shown in one case of granulocytic leukemia, one case of lymphocytic leukemia, and one case of reticulum cell sarcoma. Evidence of tumor effect in nine other cases is presented, but the significance of these cases is less clear. No enhancement of therapeutic value and no protection of the hematopoietic system is provided by the addition of ACTH or Cortisone to the regimen for OPSPA in Group II cases.

A Dietary Study in Haiti. Faye W. Grant and Dale Groom. Jour. Amer. Dietetic Assoc. 34: 708, July, 1958.

As part of a research study on the incidence and degree of coronary and aortic atherosclerosis in the Negroes of Haiti as compared to the Negroes of the Charleston, South Carolina area, the dietary habits as well as autopsy specimens in both population groups were investigated. This publication reports a survey of typical diets of upper, middle, and lower class Haitians. A similar study in the South Carolina group is to be reported in a forthcoming companion publication.

Average diets of more than 100 families and individual adult subjects ranged from 1,000 to 2,300 calories per adult per day, with mean protein intakes of 25 to 72 grams, and fat 27 to 94 grams. More than half of the adults weighed were from 5 to 30% below United States weight standards for height and sex. Haiti's economy of scarcity, typical of that of many peoples of the world, affects profoundly the nutrition of its people.

Spectrophotometric Examination of Hemoglobin. W. M. McCord, M. D. and R. H. Gadsden, Ph. D., Am. J. Clin. Path. 29: 403-411, May 1958.

Absorption spectra of hemoglobins A, S and C were determined in the 200 - 700 millimicron region. Small differences in the spectra of the various hemoglobins were demonstrated.



PRESIDENT'S PAGE

A physician may choose whom he may serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and, unless he has been discharged, the doctor may discontinue his services only after giving adequate notice. He should not solicit patients.

While it is perfectly permissible and true that any doctor can choose whom he will serve, it would be a tragic mistake for him to refuse a call to a bona fide emergency case except in the event of the physician's illness or his attendance on another case that he may not safely absent himself from temporarily. All of us have had this situation arise many times in our practice. Whether the patient's personal physician arrives or is not seen until later all ethical doctors will advise him about the condition of his patient, the treatment administered, and retire from participation in the handling of the case.

During our practices we are sometimes urged by laymen to criticize the treatment methods employed by one of our fellow physicians. If, as doctors, we should fail to employ the proper ethical procedures in such cases a general disregard for all of our moral principles would ensue.

The South Carolina Division of the American Cancer Society, 1001 Main St., Columbia, S. C., has a number of medical films on the cancer problem that are available to hospital staff or county medical society groups. These films have projection times of between 15 to 35 minutes and may be borrowed for showings by writing to the above address.

The scientific program for the May meeting in Columbia should be interesting to all groups as it will cover surgical, medical, obstetrical, pediatric, orthopedic and urological speakers. It is in its final phase of development and should be completed in a short time.

R. L. Crawford, M. D.
President

Editorials

CONFERENCE ON HANDICAPPED CHILDREN

In the spring of 1957 a successful conference of the many people and agencies concerned with children with handicaps of various kinds was held in Columbia under the auspices of the Nemours Foundation. The proceedings of the conference have been published and give a clear picture of what is being done for the handicapped child in South Carolina.

To discuss progress in this field, another conference under the same arrangement is planned for November. The tentative program is to be found elsewhere in this issue of the Journal, and it is expected that a very beneficial meeting (which is open to all who are interested) will result in a fresh evaluation of activities and planning for further improvements.

ADENOVIRUS VACCINATION

With increasing knowledge of reasonably successful vaccination against the adenovirus infections comes the development of commercial vaccines and a certain pressure of advice as to their general use.

A recent article gives insight into the necessity of general vaccination in terms of frequency of occurrence of the infection. Contrary to the available information on the high incidence in military recruits is the result of a study covering a four year observation of a university student group and a shorter period of study of third grade school children. In the first group with respiratory disease only one per cent of cultures showed adenovirus, and in the second group of well children only 3 adenoviruses were isolated from 1194 throat swabs. This small incidence of these viruses makes the authors feel, as have other investigators, that general public vaccination is not indicated. Individuals may wish to protect themselves against the remote chances of adenoviral infection. *New England J. Med.* 259:464

THE LIBERAL EDUCATION IN MEDICINE

Recent Russian technological progress has made us all aware that we must push fast to surpass our competitors. The surge of concern over our apparent deficiencies has led to great public interest in the encouragement of technical education and skill, possibly with a parallel development of disfavor for the more liberal educational elements. The same trend in medical education is not new, and has long concerned medical educators.

In early American medicine, the one practitioner in ten who achieved the degree of doctor of medicine was a man of rather broad education. Such an achievement was desired and accepted. Later, emphasis on the liberal training was removed, so that the proprietary schools turned out large numbers of poorly trained practitioners who could meet the increasing demand for medical services. Only after the beginning of the present century was there a real return to the feeling that a physician should be a man of education in the liberal arts, which provided a mental discipline essential to the proper practice of medicine. A few voices crying in the educational desert were heard but not heeded. Even as late as 1910 there was expression of a feeling that technical demands of medicine were so great that liberal preliminary training was excluded.

In 1909 Dr. W. F. R. Phillips, one time professor of anatomy at the Medical College of South Carolina expressed the same idea, but by 1918 he had changed his opinion so much that he voiced the thoughts which were developing rather generally as follows;

"Experience has shown unmistakably that progress in medicine has been often halted by the intellectual habit of seeing only straight ahead. Progress in medicine, efficiency in individual practice, would undoubtedly be greater if medical men could have more extensive acquaintance and familiarity with the facts and views of nature which are constantly being contributed by workers in other fields of endeavor. We all wish progress to be made in our profession and, I be-

lieve, the best way to make that progress is by keeping in touch with what is going on in other fields about us. Our profession, our science, is in reality built so largely on the general foundations of knowledge, as largely as it is on the special foundation that we made in our medical curriculum, and the best educational preparation to bring to the study of medicine is the study of everything else than that which one will study specifically in the medical school."

Changes in medical education soon went along with the broadening of the curricula of other fields. Premedical requirements were increased and subjects of study other than the technical were encouraged. Dr. Phillips had more to say;

"Now, there is one serious objection to prescription in relation to preliminary preparation to the study of medicine, and it is this: Medicine is a specialization in the field of knowledge; . . . Now, the whole trend and tendency of specialization, in medicine or in any other profession or business, is toward . . . intellectual obliviousness to all except the special purpose for which the special education was had and for which the profession or business exists."

Many others spoke along the same line.

"Nowhere in the literature is there a clearer intimation of the changes to come than in an article by Dr. Robert Wilson, Jr., of Charleston, South Carolina. 'The living human being is not reducible to physical and chemical reactions; he is a psychological being as well, and is the product of long and complex heredity modified by his peculiar social environment, an understanding of which fact is essential not only to the proper handling of patients, but to the comprehension of the social and economic bearings of pathological conditions.'"

The use of these quotations does not imply that our Medical school was the leader in this movement, but obviously the representatives of the College were ready to do their part in calling the tune for the times.

But the tune has not been well played—A recent statement says;

"The Committee was impressed by the extent to which narrow vocationalism dominated the minds of many students in our colleges of liberal arts. These students have little or no conception of the meaning of liberal education; they have come to college to prepare themselves to earn a living."

The excellent article* from which most of these remarks have been taken concludes:

"Unless all signs fail, we are now experiencing another scientific revolution—this time with the focus on the physical sciences. The lesson of history is clear: again there is a choice to make between the immediate goals of technical skill and the deferred goals

of liberal education. The pressure of present-day scientific needs is great. It will take clear vision and monumental tenacity to maintain an optimum balance between technical and liberal studies."

*K. P. Bunnell: *Liberal Education and American Medicine*. *J. Med. Educ.* 33:319.

A MEDICAL LITANY

The following, an extract from a letter published in the *British Medical Journal* in 1953, was written by Sir Robert Hutchison, Bart., M.D., F.R.C.P., Hon. LL.D. (Edin.) and D.Sc. (Oxon), Consulting Physician to The London Hospital and to The Hospital for Sick Children, Great Ormond Street; Past President of the Royal College of Physicians of London, and Past President of the British Paediatric Association. Sir Robert, living in retirement, is 88 years of age.

"From inability to let well alone; from too much zeal for the new and contempt for what is old; from putting knowledge before wisdom, science before art, and cleverness before common sense, from treating patients as cases, and from making the cure of the disease more grievous than the endurance of the same, Good Lord, deliver us."

REPORT OF DELEGATE TO THE A. M. A.

Sunday afternoon at the Annual Conference of Presidents and other officers of state medical associations four speakers gave excellent talks.

Dr. E. L. Bernhardt of Milwaukee talked on "Drought at the Grass Roots." As can be guessed he outlined the difference between actual politics—how doctors never seem to get steamed up until a crash program is necessary instead of taking the lead when candidates are elected to run.

Senator Wallace F. Bennett of Utah gave a splendid talk on inflation. He used infection as an analogy and carried it right through. He emphasized what Dr. Bernhardt had already said. He compared the socializing influences prevalent in Congress today to snake oil and magic and their exponents to witch doctors. Whatever is given away today must be repaid tomorrow with interest and overhead for operation. He is on the Senate Finance Committee and we should all be thankful that a man of his integrity and ideals is one of the guardians of our funds. In the end he wound up by asking—do we want security or opportunity, work or ease, truth or magic, personal responsibility or a welfare state?

Mr. Rowland Jones, executive vice president of the American Retail Federation, made a valuable suggestion. So many different organizations, and there are thousands, feel the same way physicians do about socialization and government controls that all interested should unite and present a common front. For example, the big lumber companies are fearful that the government will take over their forests but we as physicians never say a word till something that affects us comes up. The lumber companies never say anything about socialized medicine but howl only when their domain is invaded.

Mr. Frank Barnett of the Richardson Foundation, Inc., was a fitting clean-up man. He held his audience spellbound for almost an hour. Every congressman, every college student, every teacher, every person in the United States should hear that young man talk. His description of what Russia is doing while we doze in apathy is unbelievable. He has a better grasp and a better solution than anyone I've ever heard speak on the subject. Among many other things he compared the Turkish soldier and the American in Korea. The former is taught from birth to believe in and be proud of and fight for Turkey. There was no brain washing among the Turks. The American because of his less stern upbringing in geopolitics was all too often confused and disoriented and frequently broke down and even died because his thinking apparatus had not been conditioned sufficiently. I've never heard a better sizing up of the pickle into which we have drifted.

As usual a great many items of interest to physicians over the nation were brought up. One that caused the greatest argument was from Colorado concerning the relationship of physicians to the United Mine Workers. That will be touched on only briefly because it is of little concern to the physicians of South Carolina.

It is refreshing to know that income was increased by dues from 2,600 additional physicians in 1957. Income from stocks and bonds increased from 2.97% in 1956 to 3.16% in 1957. The general manager, trustees, and treasurer should be congratulated on the management of the A. M. A.'s fiscal affairs.

Aviation medicine concerns us all and the A. M. A. has gone on record as favoring improvement of medical facilities in the Civil Aeronautics Administration. It was brought out that some air lines don't even require periodic physical examinations of their personnel. The A. M. A. strongly endorses the passage of S 1045, 85th Congress, which would eliminate most of the present weaknesses.

Voluntary retirement plan was again brought up. The Board was urged to ask Congress to institute an investigation into the entire social security system and to urge the adoption of a system of "sound actuarial principles and including a combination of the insurance and annuity principle with investment in the growth of the nation's economy through equity

participation such as is now available through the mutual funds."

In keeping with changes in our physical world the A. M. A. was asked to form a Committee on Atomic Medicine and Ionizing Radiation. Its initial activities and primary responsibilities are described under several headings (1) Education of medical students and physicians (2) The formation of recommendations on A. M. A. policies concerned with the use of radioactive material (3) The formulation of A. M. A. policies concerning governmental legislative action.

The Medical Association of the Virgin Islands has applied for membership in the A. M. A. as a constituent member. This is an uncommon event but if all legal and procedural steps are in order that association will be accepted. Alaska, Hawaii, Canal Zone and Puerto Rico are already members.

The A. M. A. *News* will soon be coming out now. It is an account of facts and happenings of interest to doctors and will be published by the A. M. A.

A resolution asked for closer coordination between the A. M. A. and the Washington office of the A. M. A. This resolution was welcomed by the Board of Trustees as well as the different committees involved. To be effective in Washington a strong and thoughtful program with full support and backing of headquarters must be maintained.

The resolution introduced by the South Carolina delegation asking for an official stamp on the A. M. A. membership card certifying membership in the S. C. Medical Association was referred to the Executive Vice-President, Dr. Lull.

The United States government along with the Rockefeller Foundation is anxious to experiment in Puerto Rico with a system of medical care by doctors and hospitals whereby all rich and poor will be taken care of in all illnesses. The House of Delegates disapproved this scheme and so notified all parties concerned. This is an excellent example of how the House operates. The one man delegation from Puerto Rico was aware of what was about to take place and spread the alarm. I doubt if one percent of the doctors in the House had any idea such a scheme was afoot. "The price of freedom is eternal vigilance" was rarely better exemplified.

The reference Committee on Reports of Officers summed up President Allman's splendid speech in this manner; (1) that every physician rededicate himself to the service of mankind and that every medical society strengthen its disciplinary system to prevent the very few from besmirching the vast majority. (2) that we as members of the medical profession, and as American citizens, be high minded incorruptible men and women above reproach, and (3) that the House of Delegates and the entire medical profession continue to have a profound sense of duty and social justice, and that the final criterion of any contemplated step be the greatest good for the greatest number.

A resolution on medical care of the indigent was approved. It recommended that any money for medical assistance be given through Blue Shield or some other organization specified by a state medical association.

A resolution condemning Medicare because it is a fixed fee system was disapproved. Each state is urged to negotiate the type contract it likes best. Rhode Island has never come in to the Medicare program. Ohio is in on an indemnity basis and Texas has recently voted to get out of it. The vast majority in the House feel that it is a good thing especially when doctors have a part in establishing fees.

The United Mine Workers Welfare and Retirement Fund was condemned as lowering the quality and availability of medical and hospital care to its beneficiaries and the A. M. A.'s public relations department was urged to start an immediate campaign in all areas involved publicizing the stand and attitude of the House of Delegates.

Free choice of physicians was another resolution. This is brought up at almost every A. M. A. meeting for the simple reason that government or some other bureaucracy is constantly trying to become a third party between physician and patient.

The reference committee on Legislation and Public Relations, after a great deal of discussion, emphatically opposed social security for physicians. New York State delegation, under instructions from the N. Y. Medical Association, introduced about four different resolutions calling for a referendum (which is not called for in the A. M. A. constitution and by-laws) of all physicians. Connecticut asked permission to have social security for its physicians regardless of the other doctors in the nation and that was disapproved because there are certainly some physicians in Connecticut who do not want social security.

Objection to Forand-bill type legislation was again emphasized.

A resolution requesting tax deduction for higher education tuition was approved but referred to the Committee on Legislation.

Medicare was approved again but the decision as to fees whether indemnity type or complete payment was left to the individual states.

Jenkins-Keogh bill was again approved and physicians everywhere were urged to contact their members of Congress urging approval.

Service connected disabilities only were urged for admission to Veterans' Hospitals. In 1957 the Federal Government spent \$619,614,000.00 on hospitalized medical care of veterans in Veterans Hospitals in 1957 of which about 75% had non-service connected disabilities. What a splendid way to save ourselves some taxes. No one objects, in fact everyone wants all veterans to receive medical care at government expense for disability incurred in service but not some incidental disease that comes on years after discharge from the service.

The House of Delegates urged the Board of Trustees

through the appropriate councils and committees of the association to effect a liaison with the Department of Defense for the purpose of effecting a more equitable call up of physicians in time of a national emergency.

The reference committee on Hygiene, Public Health and Industrial Health approved the work of the committee which advises movies, radio, and television. This committee especially in Hollywood has been most effective in more sensible advertising.

The second in a series of Guides to Medical Rating of physical impairment—this time the visual system—will soon be available. It is urged that everyone remember that these are guides only and not some hard and fast rule.

The House of Delegates was requested to endorse the mouth-to-mouth type of resuscitation as being the most effective method, but the House is reluctant to become a committee to approve or disapprove any method of treatment.

The committee urged approval of a resolution against "mass advertising of proprietary drugs for symptomatic self-medication." A great many people have taken proprietary drugs lured on by high pressure advertising when they should have seen a doctor.

The House reversed an amended resolution of the committee on voluntary health agencies. The committee felt that some members of the House were trying to prevent the American Medical Research Foundation of the Board of Trustees from receiving and disbursing funds for research, from accepting funds from United Funds. Representatives of the voluntary health agencies, heart, polio, cancer, multiple sclerosis, were all against the Research Foundation accepting funds from the United Funds. The House agreed with the voluntary health agencies. Perhaps later this misunderstanding can be corrected.

The A. M. A. Distinguished Service Award went to Dr. Frank Krusen for his valuable work at Mayo Clinic in rehabilitation and physical medicine.

The Joseph Goldberger Award went to Dr. Sydenstricker of Augusta for his work in nutrition.

There were two high school winners in the National Science Fairs: Clara L. Chapman of Missula, Montana, for her work on sensitized mice and David R. Brown of Minneapolis for his work on "Humeral Transplants." It is gratifying to know that most of these candidates who enter the National Science Fairs go into medicine.

President David Allnan pointed to some of the important accomplishments during his term of office: (1) The A. M. A. newspaper. (2) The special editions of the A. M. A., one on impairment, one on interpretations by Judicial Council on Principles of Medical Ethics. (3) Renovation of the A. M. A. headquarters. He has made an outstanding president and he urges that we as physicians continue to take a positive attitude and part in our governmental affairs.

Dr. Gunner Gundersen of Lacross, Wis., was inducted into office. He made a splendid speech which

every physician probably has read by now. He urged that medicine world wide be used as a means of inducing peace.

A pleasant occurrence at every regular A. M. A. meeting is a short talk by two members of the student A. M. A., Carwile LeRoy of Chapel Hill and E. Conway Stratford, Jr., of Los Angeles were the ones this year. The former told how a medical student at the University of Virginia read in a paper about interns striking in New York for higher salaries. He was horrified that he should be going into a profession that would strike. He sought help from the A. M. A. and it was granted to start the student A. M. A. Carwile LeRoy paid back \$7,500.00 that the A. M. A. had loaned his organization. Receipt of the money for the A. M. A. or its different organizations makes all delegates happy. E. Conway Stratford, Jr., also

made a nice talk in which he expressed his gratitude for all that the A. M. A. had done for him.

Our state president, R. L. Crawford, was very much in evidence at meetings of different committees. Many doctors from South Carolina attended the convention in San Francisco. George Durst was there with all his family. He asked me if I had brought mine—I told him I couldn't afford to bring mine. He 'lowed that he couldn't either but that he had.

A trip to an A. M. A. meeting is well worth any doctor's time and money. Dr. Tom Spies is the source of the statement that no way in the world can a doctor keep up as well as by attending the scientific sessions and displays of the A. M. A. He hasn't missed either the regular meeting or the clinical session in years.

George Dean Johnson, M. D.



BLUE CROSS . . . BLUE SHIELD



POLICY REGARDING EPILEPSY

Epilepsy is classified by Blue Cross - Blue Shield primarily as a nervous or mental disease. As such, its treatment is assigned benefits for a maximum of 15 days only in any one contract year and only then when such treatment is given in a general hospital. Epilepsy and other nervous and mental diseases would not be covered at all by the Blue Cross contract except for the fact that there are instances when the nature of the illness is not known at the time of hospital admission. So two weeks with benefits are allowed to establish a firm diagnosis. After such a diagnosis has been established, theoretically, no further Blue Cross benefits should be allowed. In practice, however, two weeks of hospital care may be claimed in each successive contract year.

With regard to epilepsy, the following principles apply in administering Blue Cross benefits: When a patient is admitted to hospital shortly after, or during a convulsion of unknown cause, he is entitled to full hospital benefits. These may be continued up to a maximum of 15 days, if needed. If the patient is a known epileptic and is admitted immediately after or during a convulsion, he is entitled to not more than 15 days of hospital care in the current contract year. If the covered days have already been expended, he is entitled to no more benefits simply because of the fact that he had had a convulsion.

However, if a known epileptic injures himself during a seizure, he is entitled to hospital benefits for treatment of the injury, only, irrespective of the benefits allowable for the treatment of epilepsy.

Also, known cases of epilepsy, with uncontrollable

seizures (status epilepticus) even though their covered hospital days have already been expended, will be extended further benefits until the seizures are controlled.

Also, known cases of epilepsy, or those so diagnosed during a covered period of 15 hospital days, which are found to have organic lesions of the brain suitable for surgical treatment, will be entitled to hospital benefits, incident to hospitalization for such surgical treatment.

Known cases of epilepsy which are admitted to hospital for diagnostic surveys in relation to the epilepsy fall within the limits of not more than two weeks' hospital care per contract year, and in addition, they are entitled to diagnostic benefits only when so admitted.

Known cases of epilepsy which are hospitalized for treatment of a concurrent disease or condition are entitled to such benefits as the concurrent disease warrants without regard to the epilepsy.

Other nervous and mental conditions, including the various manifestations of the neuroses, mental retardations, and even the psychoses, are handled by Blue Cross in a manner similar to epilepsy. In reporting services to any of these cases, it should be made clear by the attending physician in his report and also to the hospital that the primary reason for the hospital admission and treatment is either diagnostic in reference to the nervous and mental condition, or that admission is primarily for the treatment of a concurrent illness and not for the treatment of neurosis or other mental condition.

J. Deherd Guess, M. D.
Medical Director

NEWS

SOUTHERN MEDICAL ASSOCIATION

Formal opening of the \$250,000 home of the Southern Medical Association was held in Birmingham, Alabama on September 7.

The new headquarters office building represents several years of planning and more than one year of construction and in the words of Association president Dr. W. Kelly West, Oklahoma City, is "a magnificent monument to Southern medicine."

More than 1,000 guests streamed through the ultra-modern, split-level home office building during the hours from 2 to 5 P. M. Dedication ceremonies were held at 4 P. M.

Distinguished guests representing the medical profession, local and state officials, lay and Auxiliary leaders were among those present.

Remarks by past presidents whose administrations coincided with the conception of the building plan, initiation and construction of the home office, were features of the dedication program. Dr. R. L. Sanders, Memphis, who as SMA president in 1954-55, is credited with getting the building movement under way, declared that the idea for a permanent home for SMA originated with the organization's pioneer members and many persons had been instrumental in bringing it to fruition.

Dr. J. P. Culpepper, Jr., Hattiesburg, another president who helped guide the building to completion, called it "a milestone in SMA history." "This is not just a building, but a home," he said. "It is a symbol of our progress in the past and our aims for the future."

Dr. Lee F. Turlington, Birmingham, who served as chairman of the home building committee, paid tribute to architect and landscape artists "who created a beauty spot where once was an eyesore." He added that the building adds immensely to the "dignity and stability of the organization."

Speaking for the SMA staff, Executive Director V. O. Foster pledged "dedicated service to all the doctors of the South who have made this monument to medicine possible."

Dr. A. Clayton McCarty, past chairman of the SMA Council, made the official presentation of a portrait of C. P. Loran, who has served the organization as professional relations director for 46 years and who led the building fund drive.

Mrs. Walter L. Curtis, College Park, Ga., president of the SMA Woman's Auxiliary, called the building "a laboratory of fellowship and a castle in the air come to earth."

Dr. John H. Buchanan, Birmingham, chaplain Baptist Hospitals, offered the dedicatory prayer. Presiding was Dr. Milford Rouse, Dallas, president-elect of the Association.

The program ended with presentation of the flag

of the United States by the color guard of the Gen. Gorgas Post No. 1, American Legion, with C. W. Nicholson, president of the Jefferson County American Legion Council, in charge.

The new home office building is a split-level structure fronting on Highland Avenue at 26th St. So. In addition to providing a meeting place and business center, a library-conference room, Woman's Auxiliary headquarters and other work areas, it contains space for the monthly Southern Medical Journal, an outstanding and widely-read publication for physicians. The Journal is distributed not only in the United States but in 22 European, South American and Asiatic countries.

SMA, which now has 13,000 members, has maintained headquarters in Birmingham for 43 of its 52 years. It was founded in Chattanooga in 1906 and offices were in Mobile before being moved here in 1913.

SOUTH CAROLINIAN ACHIEVES MEDICAL UTOPIA

Pediatrician Appointed Career Investigator by
American Heart Association

"Dr. Lewis W. Wannamaker, Associate Professor of Pediatrics, University of Minnesota, has been awarded a Career Investigatorship by the American Heart Association. This provides life-time support for research. One cannot apply for this honor but is selected by a Committee on the basis of his achievements and promise. He then lives an Utopian existence as he may follow any line of study he chooses and need produce scientific papers only when he feels such are justified." *Pediatrics* 22:607

MEDICAL COLLEGE OPENS

The opening assembly of the Medical College of South Carolina was held on September 11th.

Dr. Robert L. Crawford of Lancaster, president of the South Carolina Medical Association and a 1923 graduate of the medical college, was convocation speaker.

Among the special guests at the convocation were Dr. Henry C. Robertson of Charleston, vice president of the S. C. Medical Assn.; Dr. J. Howard Stokes of Florence, treasurer of the S. C. Medical Assn., Dr. J. P. Cain of Mullins and Dr. Keitt H. Smith of Greenville.

Dr. Kenneth M. Lynch, president of the medical college, presided at the opening exercises. A luncheon for the college's special guests was served at the Medical College Hospital.

An overall enrollment of almost 700 students is expected at the Medical College during the 1958-59 academic year.

Delegates to the 38th annual Sertoma International convention elected Dr. C. Tucker Weston, Columbia, S. C. vice president.

Dr. Roland M. Knight has opened an office at 9 Summer St. for the practice of orthopedic surgery, the Greenville County Society public relations committee has announced.

He was born in Greenville County, and is a graduate of Duke University, attended the Medical College of South Carolina, graduating in 1952, and interned at Jefferson Davis Hospital, Houston, Tex.

He served an orthopedic residency under the Baylor Medical School residency program and then spent two years in the U. S. Air Force at Sheppard Air Force Base, Tex. He recently completed a year of children's orthopedic residency at the Shriners' Hospital for Crippled Children.

A memorial tablet honoring the late Dr. James Iverson Gallimore has been erected in the library of the Medical College of South Carolina by members of his class of 1956.

Dr. Gallimore was killed in an automobile accident only a short time following his graduation.

The inscription on the tablet reads: "To the memory of James Iverson Gallimore, M. D. June 2, 1931—June 23, 1956. This tablet is erected in loving memory by his classmates. Graduating Class of 1956."

Dr. W. B. Ardrey, III, has joined Dr. Sam G. Lowe, Jr., of Rock Hill, as associate in the practice of pediatrics.

A graduate of Fort Mill High School and The Citadel, he received his MD degree from Duke University School of Medicine. After rotating internship at Brooks Hospital, San Antonio, Tex., he served in the Army Medical Corps in Korea.

Following his tour of army duty he returned to Duke Hospital for residency training in pediatrics. After completion of residency he took a year's fellowship in pediatric cardiology at Duke Hospital and served as instructor in pediatrics in the Duke University School of Medicine.

James L. Altman, M. D., announces the opening of his office for the practice of General Medicine at Dorchester-Waylyn Shopping Center, Charleston.

A crowd estimated at approximately 1,000 persons gathered at the McCormick Community House in McCormick to pay homage to Dr. Claude H. Workman who just observed his 70th birthday.

A program was presented prior to the picnic lunch with Mayor Thomas B. Minor acting as master of ceremonies. A silver service was presented Dr. and Mrs. Workman. A birthday cake and a corsage were for Mrs. Workman.

Dr. Kenneth Huggins has assumed his duties as an assistant physician of the women's department, Columbia Unit, South Carolina State Hospital, Supt. Dr. William S. Hall has announced.

Originally of Columbia, Dr. Huggins attended the



"I'M DREADFULLY SORRY, DOCTOR—GETTING YOU UP IN THE MIDDLE OF THE NIGHT!"

local schools, graduated at Carlisle Military Academy, Bamberg, received his pre-medical training at the University of South Carolina, and secured his medical degree from the Medical College of South Carolina, Charleston, in 1957 . . . During the summer of 1955 he participated in the junior internship program at the S. C. State Hospital . . . His internship was served at the Columbia Hospital from July 1, 1957 until June 30, 1958.

New Medical Journal.—The first issue of *Diseases of the Colon & Rectum*, sponsored by the American Proctologic Society, was the January-February issue. Dr. Louis A. Buie, Sr., Rochester, Minn., is the editor-in-chief, and Dr. Harry E. Bacon, Philadelphia, the executive editor.

J. Franklin Graves, M. D., announces the opening of his office at 96 Rutledge Avenue, Charleston. Practice limited to Internal Medicine.

FLORENCE TO BE SITE OF ALCOHOLICS CENTER

Recently the board of commissioners of the Florence-Darlington Tuberculosis Sanatorium voted to give 25 acres of land on the sanatorium property for construction of a state alcoholic rehabilitation center.

Five acres had originally been set aside for the center. The additional plot was voted to meet a State Alcoholic Rehabilitation Commission request for 25 acres.

The state commission decided on the Florence location for the new \$150,000 center after considering several sites throughout the state.

Legislation enabling the sanatorium commission to convey the land for the alcoholic center must be passed in the General Assembly, since attorneys for Florence and Darlington Counties agreed the power of conveyance is not vested in the sanatorium commission.

Also specified by the state commission was that the counties of Darlington and Florence clear the land for construction and that their county delegations work toward obtaining hard surfaced roads leading to the alcoholic center.

Dr. George C. Strozier has joined the State Hospital staff in the men's department, Columbia Unit of the hospital. . . . A native of Newman, Ga., Dr. Strozier graduated from Emory University with an A. B. degree in chemistry, and in 1946 received his medical degree from the same university. . . . He has practiced in Knoxville and Atlanta.

Edwin Bradley, M. D., a native of McCormick, has opened an office for the practice of obstetrics and gynecology at 120 Lucille Ave., Easley.

Dr. Bradley served with the U. S. Navy. He received a B. S. degree from the University of South Carolina, and the M. D. degree from Medical College of South Carolina in 1952. He served his internship at Columbia Hospital.

Dr. Bradley has served with the U. S. Air Force, being stationed at Donaldson AFB. For the past two years he has served as resident physician in obstetrics and gynecology at Greenville General Hospital.

VOLUNTARY HEALTH INSURANCE

The number of people in South Carolina covered by voluntary health insurance has reached a new high, the Health Insurance Council reported today. The Council estimates that over 1,193,000 persons in the state now are protected by some form of insurance designed to help pay hospital and doctor bills.

This figure, the Council said, is part of the continued growth of health insurance throughout the country, which was revealed in its 12th annual survey of the extent of voluntary health insurance coverage for 1957. The number of people covered by some form of health insurance in the nation, according to a Council estimate, is now 123,000,000, or 72% of the total U. S. civilian population.

The Council survey, based on reports of insurance programs of insurance companies, Blue Cross-Blue Shield and other health care plans, points out that the 1,193,000 persons covered by hospital expense insurance in South Carolina as of December 31, 1957, surpasses the 1956 year-end total of 1,176,000.

The number of people with surgical expense insurance, which helps to defray the cost of physicians' charges for operations, climbed to 1,016,000 as compared to 953,000 in 1956.

Persons protected by regular medical expense insur-

ance, providing for doctor visits for non-surgical care, rose to 349,000, compared to 341,000 the year before.

The Health Insurance Council, which is a federation of eight insurance associations representing over 90% of the accident and health insurance business handled by insurance companies, stated that this growth reflects the desire of the people of South Carolina to help protect themselves against the cost of accident and illness.

Twenty-three prominent physicians, nurses, social workers, hospital administrators, and public health officials met in Roanoke, Virginia in June, at the invitation of the Public Health Service to consider organized home care programs in the United States. Citing the fact that there are now approximately 50 programs functioning in this country which provide coordinated health services to patients in their own homes, the group urged more widespread development and support of such community programs by Federal, state and local health and welfare agencies; the health and health-related professions; and health insurance agencies.

The group's major recommendations were that:

1. The Public Health Service support demonstration programs to initiate and stimulate organized home care programs in various community settings.
2. Prepayment plans should meet the challenge of financing organized home care programs. Funds should be made available to do studies of the feasibility of this.
3. Public welfare agencies should pay full reimbursable costs for services to their clients.
4. Health and health-related professions should give special attention to the recruitment and training of personnel needed in organized home care programs.

The kind of program advocated by the expert group was defined as follows: "Organized Home Care provides coordinated medical and related services to selected patients at home through a formally structured group comprising at least a family physician, a public health nurse, and a social caseworker, assisted by clerical service. To insure satisfactory functioning of such a service, patients must be formally referred and there must be an initial evaluation, monthly review of records, and a final discharge conference. There must be ready access to in-patient facilities."

The advantages to the patient that organized home care provides, which were pointed out during the four-day meeting, include: increased emotional security of being in his own home and being cared for by his own family; the availability of a variety of medical and related services supplied to him as he needs them; the knowledge that a hospital bed is awaiting him if his condition should change; and the assurance that the prescription for his treatment, while being the responsibility of his physician, was arrived at after consultation of a team of health professionals. Other advantages of such programs are that they may

be administered by hospitals or by a variety of other community agencies. The fact that such programs provide service to patients of all economic levels and assist the private physician in the care of his own patient was also emphasized.

**NEW INFORMATION SERVICE LAUNCHED
FOR DOCTORS IN NORTH CAROLINA,
SOUTH CAROLINA AND VIRGINIA**

An information service unique to the Southeast is being launched for physicians in North Carolina, South Carolina and Virginia, it was announced recently.

The service will feature a monthly booklet, entitled "What Goes On," which will list all medical meetings, special lectures, post graduate courses and other events of interest in the three-state area. Distribution will be free to practicing physicians and medical faculty members.

Dr. William M. Nicholson, director of postgraduate medical education at the Duke University Medical Center, said the booklet will be prepared by the Center, in cooperation with medical societies and schools in all three states. Financial sponsorship will come from the Lederle Laboratories Division (a pharmaceutical firm) of the American Cyanamid Co.

The "What Goes On" office at Duke also will serve as a "clearing house" for medical activities in the area, Dr. Nicholson noted. Medical organizations will be invited to check with the office before scheduling meetings, thus avoiding conflict of dates. In addition, the office will offer its services to visiting physicians so that their stay in the Carolinas or Virginia may include attendance particularly interested.

Miss Frances Thomas of Durham has been appointed coordinator for the "What Goes On" booklet. The first issue is tentatively scheduled for November.

The tri-state booklet will be the third venture of its kind in the United States. Other "What Goes On" publications are available for physicians in New England, New York and Texas under Lederle auspices.

ANNOUNCEMENTS

International College of Surgeons, Mid-Atlantic Regional Meeting, The Homestead, Hot Springs, Va., November 16-18. Write Dr. Elbyrne G. Gill, 711 Jefferson Street South, Roanoke 13, Va.

**UNC School of Medicine — Second Annual
Symposium
November 20-21 — Chapel Hill**

Postgraduate Course in Cardio- and Cerebral Vascular Diseases
Two days of small group teaching; workshops; and panel discussions.

Staffed by the Divisions of Cardiology and Neurology, with Dr. W. Proctor Harvey, Georgetown University Medical Center, as guest participant in Cardiology and Dr. Joseph M. Folcy, Boston City Hospital as guest participants in Neurology.

—FOOTBALL AVAILABLE—

Carolina - Duke game on November 22
Send checks (\$4.50 plus 25c for mailing) to UNC Athletic Ticket Office, Box 109, Chapel Hill, mentioning the Symposium.

**THE SECOND
SOUTH CAROLINA CONFERENCE
ON
HANDICAPPED CHILDREN**

Sponsored By

THE INTERDEPARTMENTAL COMMITTEE
OF STATE AGENCIES CONCERNED WITH
THE WELFARE OF CHILDREN AND YOUTH
and

THE NEMOURS FOUNDATION
Wilmington, Delaware

Will be held on November 3 and 4, 1958 at the Wade Hampton Hotel, Columbia.

Speakers:

Dr. Romaine Mackie, Head of the Federal Bureau of Special Education, Department of Health, Education, and Welfare, Washington, D. C.

Dr. J. D. Russ, Pediatrician, New Orleans, La., President of the Louisiana Council for Handicapped Children.

Dr. Chester A. Swinyard Associate Director of Children's Division. Rehabilitation Center, New York City.

Dr. Joseph Wortis, Director, Division of Pediatric Psychiatry, The Jewish Hospital of Brooklyn, Brooklyn, N. Y.

The Southeastern Allergy Association will hold its annual meeting on October 31 and November 1, 1958, at the Heart of Atlanta Motel. All persons interested are cordially invited to attend. Further information can be obtained from the secretary.

Katharine MacInnis, M. D.
Secretary-Treasurer
818 Albion Road
Columbia, S. C.

**MEETING OF THE
SOUTH CAROLINA SOCIETY OF
OBSTETRICS AND GYNECOLOGY
CHARLESTON, S. C.
OCTOBER 18-19
FORT SUMTER HOTEL**

FOUNDER'S DAY PROGRAM—MEDICAL COLLEGE

The general plan for the annual Founders' Day Symposium and Seminar at the Medical College of South Carolina has been revised. As may be noted from the tentative program, a lecture presentation is given in the morning hour which is combined with a clinic presentation in the afternoon. These clinics and demonstrations will be held in various locations in the Hospital and Medical College buildings, depending on facilities required for their presentation. In this way a participant may have opportunity to experience the practical application of the principles set forth in the morning discussions.

On Founders' Day itself selected topics presented on the two previous days are to be discussed by visiting speakers.

POST-GRADUATE SEMINAR

November 4, 1958

8:30 REGISTRATION AND GREETINGS

Presiding
Dr. John T. Cuttino
Dean

AFTERNOON SESSIONS

Clinical Demonstrations

9:00 ADJUNCTIVE AIDS IN LABOR AND DELIVERY

Dr. Edward J. Dennis, III, Assistant Professor of Obstetrics and Gynecology

2:00 OBSTETRICS CLINIC

10:00 INDICATIONS FOR THE FOUR METHODS OF PROSTATECTOMY

Dr. Kenneth M. Lynch, Jr., Professor of Urology

2:45 PYELOGRAM CLINIC

11:00 PHYSICAL AGENTS IN CARE OF NECK AND SHOULDER SYNDROME

Dr. Harry W. Mims, Associate Professor of Physical Medicine and Rehabilitation

3:30 REHABILITATION CLINIC

12:00 RECONSTRUCTIVE SURGERY OF THE FACE

Dr. Robert F. Hagerty, Assistant Professor of Plastic Surgery

4:15 CLINIC ON REPAIR OF FACIAL WOUNDS

November 5, 1958

9:00 DIABETES MELLITUS

Dr. John Buse, Associate in Medicine

2:00 DIABETIC CLINIC

10:00 PERIPHERAL NERVE DISEASE

Dr. O. Rhett Talbert, Assistant Professor of Medicine

2:45 NEUROLOGIC CLINIC

11:00 PEPTIC ULCER

Dr. Vince Moseley, Professor of Medicine

3:30 DIAGNOSTIC CLINIC

12:00 CYANOTIC HEART DISEASE

Dr. John A. Boone, Professor of Medicine

4:15 HEART CLINIC

FOUNDERS' DAY

November 6, 1958

8:30 REGISTRATION AND GREETINGS

Presiding
Dr. I. Ripon Wilson, Jr.
President
South Carolina Academy of
General Practice

AFTERNOON SESSION

9:15 DR. ROY T. PARKER

Associate Professor of Obstetrics
and Gynecology
Duke University School of Medicine
"Irregular, Excessive and Prolonged
Uterine Bleeding"

2:30 DR. JOHN S. ATWATER

Associate Chief of Medicine
Georgia Baptist Hospital

"Some Aspects of Management of
Peptic Ulcer"

10:15 DR. REED O. DINGMAN

Assistant Professor of Surgery
University of Michigan Medical School

3:30 DR. A. GORMAN HILLS

Professor of Internal Medicine
University of Miami School of
Medicine
"Diabetes Mellitus"

"The Surgery of Trauma and Reconstruction"

11:15 COFFEE BREAK

11:45 DR. JACK DUANE MYERS

Professor of Medicine
University of Pittsburgh School of Medicine
"Comments on Myocardial and Pericardial
Disease"

1:00 MEDICAL COLLEGE LUNCHEON
Alumni Memorial House

International College of Surgeons—Southeastern regional meeting, Miami Beach, January 4-7, 1959. For information, write to Harold O. Hallstrand, M. D., 7210 Red Road, South Miami, Fla., chairman.

THE AMERICAN COLLEGE OF SURGEONS OUTLINE OF SECTIONAL MEETINGS DURING 1959:

All members of the medical profession are invited to attend any of the 1959 Sectional Meetings of the American College of Surgeons.

CHARLESTON, S. C., Francis Marion Hotel, January 19, 20, 21:

DR. KENNETH M. LYNCH, JR., Charleston, and his committee of local surgeons are planning a program covering many topics of current concern, including trauma, cancer, arterial occlusive disease, management of gastrointestinal tract hemorrhage, and abdominal emergencies. Luncheon programs are being scheduled at which morning presentations will be discussed, and numerous papers will be presented. A reception for surgeons and wives will be held Tuesday evening, January 20. The Fellowship Luncheon, inaugurated with much success last year, featuring a panel discussion by College officials on activities of the College, will be repeated. One morning of clinics at Medical College of South Carolina will be included in the program.

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

Plans have been made for the Second Annual Convention of the American Association of Medical Assistants to be held at the Palmer House, Chicago, Illinois on October 31, November 1 and 2, 1958.

The American Association of Medical Assistants is made up of men and women employed as assistants in the offices of Doctors of Medicine.

The purposes of the Association are stated as follows: To inspire its members to render honest, loyal and more efficient service to the profession and to the public which they serve. To strive at all times to cooperate with the medical profession in improving public relations. To render educational services for the self-improvement of its members.

The American Association of Medical Assistants would welcome the opportunity to give information concerning the organization and to assist with the formation of County and State Societies. Inquiries may be addressed to Miss Hallie Cummins, R.R.L., Chairman of the Public Relations Committee, Medical Record Library, Caro State Hospital for Epileptics, Caro, Michigan.

DEATHS

DR. C. H. HAYNSWORTH

Dr. Curtis Hall Haynsworth, 43, orthopedic surgeon, was found dead at his home on August 15.

Dr. Haynsworth was born in Greenville and was

a graduate of Sewanee Military Academy, Furman University and the Medical College of South Carolina.

He served his internship at Emergency Hospital in Washington, D. C. and did his residency in orthopedies at Shriner's Hospital in Greenville and the Hospital for Special Surgery in New York. He began his practice in orthopedic surgery in Greenville and continued until his health failed two years ago.

DR. WILLIAM T. PACE

Dr. William Thomas Pace, 68, prominent physician of Gray Court, died suddenly at his home on July 6 after 18 months of declining health.

Dr. Pace was born in Hodges and assumed his practice in Gray Court in 1917. He was a Mason, former member of the town council, a member of the Laurens County Medical Society, South Carolina Medical Assn. and was chief of staff at Laurens County Hospital for the past 12 years. He was a graduate of the Medical College of South Carolina.

DR. G. R. WESTROPE

Dr. Gordon Robert Westrope, former resident of Gaffney and for several years Cherokee County health officer, died unexpectedly at his home in Columbia August 25.

Dr. Westrope was born in College Corner, Ind. but spent most of his life in South Carolina. He attended Wofford College summer school before receiving his medical degree at the Medical College of South Carolina.

DR. THEODORE QUATTLEBAUM

Dr. Theodore Quattlebaum, former superintendent of the John K. Crosswell Home died August 24 at the age of 82. A native of Williston, he had been ill for many weeks.

He was a graduate of Furman University and Vanderbilt Medical College. He later specialized in eye, ear, nose and throat, after taking courses at Columbia University in New York City.

Dr. Quattlebaum for a number of years practiced medicine in Batesburg and in Columbia. Later he served as superintendent of the Carolina Home in Columbia, and then as superintendent of the Crosswell Home in Sumter.

DR. JOSEPH W. McMEANS

Dr. Joseph W. McMeans, pathologist at the Anderson Memorial Hospital and a resident of Anderson since 1952, died at his home on September 2.

He was a native of Cleveland, Ohio, and a graduate of the University of Pittsburgh. He practiced in Pittsburgh and in Florence, S. C.

Dr. McMeans was credited with developing the blood bank program and with expanding the hospital's general laboratory program and the school for laboratory technicians.

DR. A. P. TRAYWICK

Dr. Asa Paul Traywick, 79, died at his residence on July 26. He had been a physician for over 50 years in Cameron.

Dr. Traywick attended Wofford College and received his M.D. degree from the Medical Department of the University of Maryland. After a year as chief resident at Lying-In-Hospital, Baltimore, Md., he went to Warm Spring Hospital, Butte, Mont., as a member of the staff.

After a year of special training in New York City, he came to Cameron. He was honored in March, 1956, by the community of Cameron for his faithful service

to the community for the past 50 years. Last June, Dr. and Mrs. Traywick celebrated their golden wedding anniversary.

DR. H. T. HALL

Dr. Huger Tudor Hall, 50, a practitioner in Aiken for twenty-four years, died August 25 after an extended illness.

A lifelong resident of Aiken, Dr. Hall attended Aiken elementary schools, Lawrenceville School for Boys and was a graduate of Washington and Lee University and the Medical College of South Carolina.

Dr. Hall began his practice of medicine in 1934.

ONE HUNDRED AND TENTH ANNUAL SESSION OF THE SOUTH CAROLINA MEDICAL ASSOCIATION. HOUSE OF DELEGATES

MYRTLE BEACH, S. C., MAY 13TH AND 14TH, 1958, OCEAN FOREST HOTEL

Dr. D. Lesesne Smith, Presiding

(Continued from September Issue)

PRESIDENT SMITH: Gentlemen, I inadvertently skipped over the Reference Committee on Amendments to Constitution and By-Laws, Dr. Hanckel.

DR. HANCKEL: Mr. President, two matters came to the attention of the Reference Committee on Amendments to the Constitution and By-Laws and they are as follows: First we considered a suggestion from the Committee on Industrial Medicine and Health, and the suggestion was that any Chairman of a standing or special committee who is not already a member, or a delegate, will automatically be made a member of the House of Delegates for that year. And the reason it was brought to our attention was because that occurred in that particular committee, this year. This was considered and it was decided that no action be taken on it because it was thought not to be a matter for state level action but rather to be handled at county level, simply received as information.

PRESIDENT SMITH: It will be so ordered.

DR. HANCKEL: Now the next matter was presented by the Committee on Care of Indigent. This first sheet was read yesterday by Dr. Miller in the absence of Dr. Siegling, and I would like to review it briefly with you to refresh your memory. (The sheet is read.) And in accordance with that, this is the change in the Constitution and By-laws that your Reference Committee wishes to propose and recommend its adoption; that we amend Chapter 8, Section 3, by adding to the list of standing committees a ninth committee to be known as the Committee on Welfare and Rehabilitation. Further, Chapter 8, Section 12, and this is simply to explain the duties and actions and composition of this Committee on Welfare and Rehabilitation, this will be an addition, under Section 12, This committee will consist of five members appointed for a term of five years by the President of the Association. Tenure of the five initially named members will progress from one to five years in the order recorded by the President. Yearly regular vacancies and vacancies occurring by resignation or otherwise, will be filled by the President. The Chairman of the body will be elected yearly by members of the Committee. The Welfare and Rehabilitation

Committee is assigned the responsibility of advisor and liaison to the several agencies in the field of welfare, rehabilitation and care of the medically indigent. Annual and interim reports will keep the Association cognizant of the needs and accomplishments in this area of responsibility. And your Committee recommends and moves the approval of these changes in the By-laws.

PRESIDENT SMITH: Thank you Dr. Hanckel. You have heard the recommendations, and this takes a two-thirds vote. Is there a second? The motion is seconded. Any further discussion? I will ask for a standing vote. It takes two-thirds majority to change the By-laws. Those in favor will please stand. Those opposed will please stand. There is no opposition, the report is accepted.

Gentlemen, the next report will be on Insurance, Blue Cross and Blue Shield, Dr. Edward F. Parker, Chairman.

DR. PARKER: I apologize for not being here sooner. The Committee presents the following report:

REPORT OF THE REFERENCE COMMITTEE ON INSURANCE, BLUE CROSS AND BLUE SHIELD

The committee considered the resolutions of the Greenville County Medical Society, the Columbia Medical Society, the Edisto Medical Society and the Charleston County Medical Society, pertaining to the practice of anesthesiology, pathology and radiology, and recommends that the Association adopt the following resolution:

WHEREAS, the practice of anesthesiology, pathology and radiology is the practice of medicine, and

WHEREAS, such services can be performed only by or under the supervision of physicians, and

WHEREAS, the South Carolina Medical Association has contracted for physicians of the State of South Carolina with the Department of Defense to supply medical services to dependents of the uniformed services under Public Law 569 of the 84th Congress (otherwise known as the Dependent's Medical Care Plan), and

WHEREAS, certification of medical services rendered

can be made only by physicians, THEREFORE BE IT RESOLVED, that the South Carolina Medical Association declares that anesthesiology, pathology and radiology are medical services under the terms of the contract which has been negotiated between the Medical Association and the Department of Defense in compliance with the Dependents medical care plan, and that fees for such services, wherever rendered, must be paid to the physicians rendering the services; furthermore, that this same principle be endorsed for the rendition of statements to all patients for such services.

The committee also recommends that this Association extend its sincere thanks to the Council for their excellent work accomplished in connection with Blue Shield, as presented in the report of the Chairman, and this committee has no recommendations for any further change in the Blue Shield contract.

The Reference Committee also considered the following Resolution submitted to it:

WHEREAS, the medical profession has consistently opposed the assumption of the responsibility for the provision of medical care for civilians in general by the Federal Government (socialized medicine); and WHEREAS, existing legislation (Medicare) does instruct the Federal Government to provide medical care for a large segment of the civilian population; and

WHEREAS, proposed legislation (Forand Bill) will instruct the Federal Government to provide medical care for another large segment of the civilian population; and

WHEREAS, such federal activities, if unchecked, will shortly lead to destruction of the private practice of medicine, which has occurred in England recently, to the detriment of patients and physicians, and the national solvency; Now Therefore, be it

RESOLVED, that the South Carolina Medical Association shall not renew the Medicare contract with the Department of Defense when this expires.

The majority of the Committee was not in favor of the Resolution, but the committee recognized the fact that the Medicare program does represent a phase of socialized medicine, and that this phase is considered to be tolerable for the present.

Edward F. Parker, Chairman
George D. Johnson
Henry F. Hall
C. R. F. Baker

PRESIDENT SMITH: You have heard the recommendation, you put that in the form of a motion?

DR. PARKER: Yes, sir.

PRESIDENT SMITH: The motion is seconded. All in favor say aye. The motion is carried.

DR. PARKER: Second, recommends also that thanks of the Association go to the Council.

PRESIDENT SMITH: If there is no objection that recommendation will be accepted.

DR. PARKER: Third, Reference Committee also considered the following resolution submitted, regarding the opposition of assumption of responsibility for provisional medical care by the Federal Government. The majority of the Committee was not in favor of the resolution, and the entire Committee was not in favor of the report; therefore I move that it be received as information.

PRESIDENT SMITH: The motion is open to discussion.

DR. E. B. POOLE: Mr. President, is it in order to discuss the matter which is received as information?

PRESIDENT SMITH: Well, Dr. Parker made a motion which was seconded, there is a motion before the House that we do not approve the resolution as brought up to the Reference Committee.

DR. POOLE: Well I wanted to know if it is in order to discuss this matter.

PRESIDENT SMITH: Yes, sir.

DR. POOLE: Mr. President, and Delegates, I am here not as an individual but as an officer of the Greenville County Society to present what I believe to be the majority opinion of our society on the issue raised by Dr. W. W. Edwards' resolution. This was presented to our Society Tuesday, May 6th and was thoroughly discussed and passed by a vote of over three to one of the members present.

Let it first be said most emphatically that the Greenville Society believes with a deep conviction that the dependents of military personnel should receive the finest medical care available, and we are obligated to render this service. But with the same conviction we have reluctantly concluded that Medicare is not the proper solution of this problem. Our opinion and convictions are based upon the following reasons:

1. We do not like the method by which the Medicare plan was submitted to the general profession as a whole and to the South Carolina Medical Association in particular. The classic carrot and stick technique was used. We hope we don't prove to be the jackasses of this classic fable. The stick: we were threatened with all sorts of dire consequences if we did not go into Medicare. It is not necessary to enumerate the propaganda measures applied. Suffice it to say all the modern pressure techniques were skillfully applied.

Now the carrot: We were told that as a reward for being good boys and go along with the plan certain of us would now receive substantial fees for services rendered to servicemen when often fees for such services were hard to collect at any level.

2. The Camel in the Tent aspect of Medicare. One further long step down the now short road to complete Federal control of medical practice. We have already arrived very, very far down this road.

3. This is one more bit of class legislation. No one can deny the service men in the lower grades do need assistance in meeting the needs of their dependents. We all agree that these needs must be met. But we do not see the equity where officers of field grade and general officers receive these benefits as a fringe benefit not subject to income tax computation, a blessing most of us would most devoutly wish to achieve. The papers of the last few days clearly indicate that certainly general officers should be able to take care of their dependents on their own resources.

4. Medicare could have been expected to be the most expensive and complicated way to solve a difficult problem, and most subject to abuse. No one needs to remind you how quickly Medicare funds became exhausted, nor how we have been subjected to the most obsessive and pedantic job of fly-specking in history. It is not necessary to point out how the system can be abused and has been abused. This is inherent in so much well-intentioned legislation, especially this one. Now will I remind you of the delays in receiving payment for your services, requests for supplemental reports, justification for charges and down-grading of fees.

5. The alternative: No such recommendation was contained in the resolution for the simple reason that though we felt we could properly request a change in policy of the South Carolina Medical Association, we could not demand an immediate change in high level policy at the Federal level, but as free citizens under the much embattled institution, state our position without fear of reprisal and as citizens record what we think is an honest, moral and equitable solution. We feel that such a solution consists in raising the pay and allowances of the lower non-commissioned grades so they can meet their obligations on their own honor and initiative like all other free American citizens.

PRESIDENT SMITH: Any further discussion?

DR. THOS. PARKER: Mr. President, ladies and gentlemen; I would like to speak very briefly on this subject, simply to call to the attention of the Delegates that we are taking what is considered to be concerted action this morning. The resolution as submitted by the Greenville County Medical Society is in essence stated. We thought that this was wrong in principle. The resolution, or the comment by our Reference Committee to us, that the Reference Committee agreed that it was wrong in principle but not sufficiently wrong to be intolerable. This opens to what we have been observing in diplomacy for a long time, and is what we commonly call appeasement. We think that if we do stand up for what we think is right the consequences will be immediate and unpleasant. If we go along we don't think the consequences will be unpleasant. So that I would like to urge upon the Delegates that if they vote for something they think is wrong, it would be difficult to defend this position, even though it might be expedient.

PRESIDENT SMITH: Any further discussion?

DR. JOE CAIN: Mr. President, and Gentlemen, this question of Medicare has various ramifications. I think that before we vote on the problem we ought to be sure we understand exactly what we are voting for. I think that because the United States Government has entered into a contract with the State of South Carolina, to pay for medical care for service men and their dependents, that that might be a part of what has been called socialized medicine, because it is a bringing of Government here into the situation. However, in this particular case it seems to me that that was the only semblance to socialized medicine in the Medicare program. I call your attention to the fact that the Government in this case is taking care of its employees who happen to be in the armed services, just as a corporation or company might take care of its employees and dependents, through an insurance program or in some cases as an insurer itself. But that doesn't follow all the way through, because we are dealing here with Government money, taxpayers' money, and we are taxpayers, and I agree that because we are taxpayers we should be concerned. However as physicians, I think that is a different question altogether, and that is what we are discussing here today. I would call to your attention the law which says that the contract may be made with the State Association; that if no contract is forthcoming that negotiations may be made with the individual doctor. It would do us no good, as I see it, to get out of the Medicare program. It would merely lessen our bargaining power and control over the situation, because under the law the Government is free to negotiate with us as individual doctors if we do not choose to do it as a medical association. Whether or not we should take that into consideration, whether we should be concerned that from the standpoint of individual doctors, and that we as an association would be sitting on the sidelines, I don't know.

The other point is that this is a contract between the Association and the United States Government. We were invited to Washington to agree on a fee schedule, and I was one of those who went as your representative. I can tell you that it is our fee schedule, and not their fee schedule. It is not the same fee schedule that is in effect in other states in the Union. Some of them are the same and some more and some less. It is our schedule that we asked them for. If we are dissatisfied with it, when the time comes to renegotiate, it is our business to change it. Those are the things that should come up if anything needs changing.

Now, I do not fear socialized medicine coming through Medicare. I recognize the bugaboo is there. I recognize it for what it is, and what might be, and I intend to keep my eyes open. If and when the situation de-

velops that goes contrary to our way of thinking and our American way of practicing medicine, I want to get out, and I want to get out fast, and I think all the rest of us do. But until that happens, and it has not happened yet, I think we should go along with it, because I believe it is a good thing. Now if it has kept just one South Carolina doctor from being drafted into the armed forces, and in talking to Dr. Owens he tells me it has kept several out, I think it is a good thing, and so long as we keep our eye on it and don't let it get out of hand, I am in favor of going along with it, and I am going to vote for the Committee recommendation.

PRESIDENT SMITH: Any further discussion? All in favor of the motion please rise. All opposed please rise. The tellers will please make their report.

DR. WESTON: Mr. Chairman, there are 66 in favor and 12 opposed.

PRESIDENT SMITH: The motion is carried.

Do you have any further report, Dr. Parker?

DR. PARKER: No, sir.

PRESIDENT SMITH: We have a supplemental report by the Chairman of Council, Dr. Cain.

DR. CAIN: Gentlemen, I would like to submit a resolution approved through the Council of The South Carolina Medical Association, which is in order, because the Council of the Association is considered as a Reference Committee for all intents and purposes; otherwise this resolution presented today would be out of order. As Chairman of Council I present this resolution in behalf of Council. Before I present it I would like to give a little information concerning the facts contained therein. You have all heard by word of mouth or by newspapers, or other methods of communication, of the so called Forand Bill. There has been some discussion in our talks here today, and I wondered if we all realized that such legislation, which calls for Government care of survivors who are now under Social Security, would have such tremendous popular appeal. Anything connected with Social Security and care of our own people has a tremendous appeal to the public. There is practically no family in the State or in the Country that is not connected in some way by Social Security, either by direct coverage or by virtue of the fact that their parents or relatives are covered under it. So that any attempt on the part of anybody to downgrade Social Security legislation, or to criticize it strongly in public is met with a rather jaundiced eye. They wonder what sort of people we are who are opposing such as that. We had that experience when we were fighting the bill which was referred to as HR7225, which had to do with total disability benefits at age 55 or age 50, and other provisions of the Social Security bill passed by Congress two years ago. At that time all the efforts we made as organized medical associations were beaten down. Whether or not the Forand bill is going to pass this year, I don't know. I do know the same tremendous popular appeal is there. Realizing this, the American Medical Association has asked that we do all that we can to fight this bill, but to do it quietly. That we ought to contact our representatives and Senators and ask them to vote against the bill, giving them our reasons and talking the matter over with them, rather than giving it widespread publicity. That has been done in our State. We have talked with our Congressmen and Senators. While most of our Congressmen and one of our Senators is with us pretty near all the way, one or two of the Congressmen and one of the Senators has given us the run around. In other words, we know just as well as we are standing here, they are for the bill, and no matter what we do or say is going to make them vote against the bill, because it has such a tremendous popular appeal. The question we found hardest to answer, when we were talking to these men, is why we were against it. We had to

agree that was some remedial agency or circumstance which were required to take care of this group of people, that we did not have at the present time, and we did not have that answer. Now the American Medical Association has been working on an affirmative approach to make. They have recently organized a Council to study this problem and make recommendations. In the hope that we might delay action on the bills, such as the Forand Bill, that is only one, there are several others of the same nature in the House, we have prepared the following resolution that we will ask you to pass, so that the full weight of the Association might be carried to our representatives and Senators so they will know how we feel about it. You will notice the resolution has no negative approach, it is a positive approach all the way, which is in line with the thinking of those people who are behind the strategy, and we hope you will approve it.

RESOLUTION

WHEREAS, The American Medical Association, American Dental Association, American Hospital Association and American Nursing Home Association, cooperating in the effort to meet the challenge presented by the increasing number of older people in the United States have established a joint council to improve the health care of the aged; and

WHEREAS, The stated objectives of the Joint Council are: "(1) To identify and analyze the health needs of the aged; (2) To appraise available health resources for the aged; and (3) To develop programs to foster the best possible health care for the aged regardless of their economic status;" Now, Therefore, Be It

RESOLVED, By the House of Delegates of the South Carolina Medical Association, that the National Congress be urged to refrain from the passage of laws which would hamper the efforts of the Joint Council by making the aged of our population more dependent upon the Federal Government, so that these great national health organizations may have reasonable time to work out the solution of the problems in the traditional American way; That a copy of this Resolution be forwarded to our two Senators and to the Representative of each of the six Congressional Districts of the State, requesting them to use their best efforts to implement the purpose expressed herein.

PRESIDENT SMITH: Do you move that the resolution be adopted?

DR. CAIN: Yes, sir.

PRESIDENT SMITH: The motion is seconded. Any further discussion? I call for a vote. All those in favor say aye; those opposed no. The motion is carried.

PRESIDENT SMITH: Now gentlemen, I believe this about concludes our business until we get to the annual election of officers. Would you like to have a five minute recess.

AFTER RECESS

PRESIDENT SMITH: The House will come to order. The next business is the annual election of officers. The floor is now open for nomination for President-Elect.

DR. FRANK OWENS: Mr. President, and members of the House of Delegates. I request the privilege of nominating this man as president-elect of the South Carolina Medical Association, because I know him well. I have known him all of my life. I have been hunting with him been fishing with him, played golf with him, been to church with him, worked on cases with him in the hospital and at home, and I know how he feels about medicine and what he has done for medicine. He has the highest ideals and beliefs, and believes in the highest principles of medical ethics. He believes in scientific medicine, and he is alert to all of the rapid changes that come into medicine. He is alert to the problems that face the medical

profession. He knows of them on the local, state and national level. He is a man that gives his time to his patients and believes the patients are the main thing. The other day I was playing golf with him and finally on the eighteenth hole I ckd out a win on him. And he says no wonder you beat me, I had to get up last night about three o'clock to see a baby and I got tired from it. So I tell you that because it indicates he is the kind of man that goes to his sick people, no matter where it is, and I happen to know this particular baby he went to see was a charity case. He is a man who has practiced pediatrics in Columbia for many years. A graduate of the University of South Carolina, Medical College of Virginia. He interned at Johns Hopkins, Chief Resident at Childrens' Hospital 1925-1926, and then he came back to Columbia in 1927, to be associated with one of the grandest doctors the State of South Carolina has produced, his father, a specialist in pediatrics. He is past secretary of the Columbia Medical Society, and they elected him their president and he served there for a year. He has been chairman of the program committee of that society since 1942, and he is responsible for many fine programs that we have had. He has been a delegate to the American Medical Association from this state since 1951, past President of the South Carolina Pediatric Society, and chairman of District 4, American Academy of Pediatrics, and on their Board of Directors. He has written and published numerous papers, articles on pediatrics, of various types, and polio, rheumatic fever and many others. He is married, has three children, one of them studying medicine now and one of them hopes to enter medical college next year. He is a man who has served this association well and served the public well, and I have the honor and privilege of nominating as President-Elect of this Association, Dr. William Weston, Jr., of Columbia.

DR. MAYER: I would like the privilege of seconding the nomination of this esteemed outstanding gentleman.

DR. LAWRENCE THACKSTON seconds the nomination.

DR. WYMAN KING: I would also like to second the nomination.

Motion is made and seconded that nominations be closed. Motion carried.

DR. -----: Mr. President, I move that the Secretary be instructed to cast a unanimous ballot for Dr. Weston.

PRESIDENT SMITH: The Secretary will cast a unanimous vote. I would like for Dr. Owens to escort the new President-elect to the platform and have a word from him.

DR. WESTON: Mr. President, fellow delegates, I humbly accept this esteemed honor, and one doesn't recognize himself so much, except that Dr. Owens did ask me to write out a few things. And there was only one mistake. If you have ever been in Virginia, you know the difference between the University of Virginia and the Virginia Medical School and the Medical College of Virginia. And I had to go and finish at the University of Virginia.

Now in regard to carrying out these various functions. No man undertakes a position or job unless there are going to be problems. We know there are going to be problems and I hope to be able to confront them with ability and with judgment, so that we can go forward and follow in the esteemed footsteps of those who have led us so greatly in the past.

In regards to the condition and situation in Charleston, I don't know of anyone who could be a better ambassador than his son, and my son is entering the medical school this fall and I am sure he will smooth all situations out which exist.

PRESIDENT SMITH: Thank you very much. Nominations are now open for Vice President.

DR. HENRY C. ROBERTSON, of Charleston is nominated and the nomination seconded.

It is moved and seconded and carried that the nominations be closed.

PRESIDENT SMITH: I instruct the secretary to cast a unanimous vote.

The next nomination is for Secretary.

DR. ROBERT WILSON is nominated to succeed himself.

DR. BACHMAN SMITH moves the nominations be closed. Seconded and carried.

PRESIDENT SMITH: I instruct the secretary to cast a unanimous vote.

Next nominations for treasurer.

DR. JOE CAIN: Mr. President, it seems as though the treasurer has to be nominated by Council and upon the advice of Council I would like to nominate Dr. Howard Stokes.

PRESIDENT SMITH: There can't be any further nominations. All in favor say aye. The secretary will cast a unanimous vote.

Next, nomination for delegate to The American Medical Association for two year term. Dr. George Dean Johnson's term expires on December 31, 1958.

DR. COCHRAN: Mr. President, I nominate Dr. Johnson to succeed himself.

PRESIDENT SMITH: If there are no further nominations I will ask the secretary to cast a unanimous vote. Alternate delegate to The American Medical Association, two year term. Dr. Charles N. Wyatt's term expires December 31, 1958.

DR. CHARLES N. WYATT is nominated to succeed himself.

Motion is made to close nominations, seconded and carried.

PRESIDENT SMITH: I will ask the secretary to cast a unanimous vote.

COUNCILLORS For three year terms. Second District is up for election, Dr. A. F. Burnside.

DR. A. F. BURNSIDE is nominated to succeed himself.

Motion is made to close nominations, seconded and carried.

PRESIDENT SMITH: Since there are no other nominations, I shall ask the secretary to cast a unanimous vote.

Fifth District, Dr. John M. Brewer, expires.

DR. LABORDE nominates Dr. Brewer to succeed himself.

DR. R. G. RENNER nominates Dr. J. B. Gaston.

The vote is on secret ballot.

DR. WESTON: I would like for Dr. Lumpkin and Dr. Marion Davis, if they are in the house, to come up and assist in tallying the ballots.

PRESIDENT SMITH: While they are tallying, the next nomination is for the Eighth District, term of Dr. J. H. Gressette expires.

DR. LAWRENCE THACKSTON nominates Dr. Gressette to succeed himself.

Motion is made to close nominations, seconded and carried.

PRESIDENT SMITH: The secretary is requested to cast a unanimous vote for Dr. Gressette.

Nominations for Mediation Committee.

DR. CAIN: Gentlemen, the by-laws state that the Mediation Committee is to be nominated by Council. The Council has made its nomination, and I will ask Mr. Meadors to read these. The first is for the Second District, will you read the name to fill the term of Dr. Weston Cook.

MR. MEADORS: Dr. Weston Cook and Dr. Sam Garrison.

PRESIDENT SMITH: Gentlemen, if you so desire we can vote for them on one piece of paper, so if you will return your ballots the tellers can count these later.

MR. MEADORS: The term of the Fifth District, Dr. Roderick MacDonald expires, Dr. MacDonald and Dr. LaRoehe.

The term has expired for the Eighth District of Dr. W. R. Tuten, Jr., Nominations are Dr. Tuten and Dr. Mike Watson.

PRESIDENT SMITH: All of these can be placed on the same ballot. Will the tellers collect the ballots please.

DR. WESTON: Mr. President, Dr. John Brewer received a majority of votes for Councilor of the Fifth District.

PRESIDENT SMITH: Thank you sir. Next election, member of Executive Committee State Board of Health, to fill the unexpired term of Dr. W. R. Mead, resigned.

DR. HOWARD STOKES, of Florence, is nominated. Motion made, seconded and carried that nominations be closed.

PRESIDENT SMITH: Since there are no further nominations, I will ask the secretary to cast a unanimous vote.

Members of State Board of Medical Examiners, four year terms. Fourth District, Dr. George R. Wilkinson, expires. Eighth District, Dr. W. R. Tuten, expires.

DR. MACDONALD moves that Dr. Wilkinson be nominated to succeed himself.

Motion made, seconded and carried that nominations be closed.

DR. THACKSTON nominates Dr. Tuten to succeed himself.

Motion made, seconded and carried that nominations be closed.

PRESIDENT SMITH: Since there are no further nominations, I will ask the secretary to cast unanimous votes.

Member of State Board of Examination of Nurses. Five year term. Term of Dr. L. Emmett Madden expires.

DR. L. EMMETT MADDEN is nominated to succeed himself.

Motion made, seconded and carried that nominations be closed.

PRESIDENT SMITH: The secretary is requested to cast a unanimous vote.

Member of Hospital Advisory Council of State Board of Health, four year term. The term of Dr. William C. Cantey expires.

DR. P. L. LABORDE of Columbia, is nominated by Dr. Sanders.

Motion made, seconded and carried that nominations be closed.

PRESIDENT SMITH: The secretary will be requested to cast a unanimous vote.

PRESIDENT SMITH: Now is there anybody that I have failed to call to be elected? If not the next matter is the selection of place for the 1959 Annual Meeting.

DR. ROBERT WILSON: Mr. President, I have been deluged with telegrams and letters from lay groups inviting the Association to hold its 1959 meeting, a letter from the Columbia Chamber of Commerce, asking us to come to Columbia, a letter from the Poinsett Hotel manager there, asking us to come to Greenville, a telegram from the Mayor of the City of Greenville, inviting us to Greenville, a telegram from the Vice President Francis Marion Hotel, extending an invitation to Charleston, and a telegram from the Manager of the Fort Sumter Hotel in Charleston, and a wire from the Chamber of Commerce in Greenville. This is purely for your information, these are not official invitations.

DR. O. B. MAYER: Mr. President, for a group of members of the Association who live in different parts of the State from Myrtle Beach, it is quite a chore, almost an impossibility at times for these men to ever attend the annual meeting. Some of them are from

small towns, and it is impractical to get to the meetings. If they spend a day here and a day back, they are away from their patients two or three days. It is the principle of this Association that we have meetings for all the members. And I think turn about is fair play. I think we should consider having our next meeting in central South Carolina, and I think further that we should consider the schedules of the members. Therefore Mr. President, I move that the 1959 Annual Meeting of the South Carolina Medical Association be held in Columbia, and that the House of Delegates in the future consider holding each fourth annual meeting in central South Carolina.

The Motion is seconded.

PRESIDENT SMITH: The motion is made and seconded that the House of Delegates consider having the meeting in Columbia every fourth year.

DR. MAYER: No, sir, Mr. President, I will read it again. That the 1959 annual meeting be held in Columbia, and in the future that the House of Delegates consider holding every fourth annual meeting in central South Carolina.

PRESIDENT SMITH: There are two parts to the motion but we can vote on the motion as a whole if you would like. And the motion was seconded as a whole as I understand. Any discussion? If not I call for a vote on Dr. Mayer's motion. All in favor say aye. Those opposed no. I will have to ask the no's to stand. There are fifteen no's. I am taking the place of the tellers, because they are busy. All those in favor of the motion please stand. Please be seated. There are thirty-six ayes in favor of the motion, fifteen against. The motion is carried.

Gentlemen, is there anything further?

DR. POOLE: May I commend the outgoing President for the expeditious way in which he has handled the business of the session.

PRESIDENT SMITH: Thank you sir, Gentleman, there is one thing I would like to remind you of. The commercial exhibitors come here at a good deal of expense, and I was here when they were setting up the exhibits and they were sweating pretty hard to get them up. These exhibitors are a very important part in support of the organization here, and I wish you would encourage all the other members to go by and confer with these exhibitors, because they really mean a lot to us and they really want you there. Any other announcements or business?

DR. HANCKEL: I would like to call the attention of the group to the fact there is a meeting of the Alumni Association coming at one o'clock.

MR. MEADORS: I want to call your attention to the luncheon Dr. Hanckel spoke of and also the banquet, which is tomorrow night, and ask you to get your tickets for the banquet as early as possible. They are \$4.00, obtainable in the lobby.

Also to remind you and call your attention to the dairy bar, which has been set up this year by the dairy industry of South Carolina, all furnished, the products, all of it is gratis. It is a very nice thing and they wanted to cooperate with us, and I think it is an asset to the meeting in place of the Coca-Cola box we had before, and I ask that you keep that in mind.

PRESIDENT SMITH: Gentlemen, Dr. Edwards would like for me to remind you that whether you graduated from the Medical College or not, we are all invited to the alumni luncheon at one o'clock. Anybody else?

DR. PRIOLEAU: Mr. President, as we are filling in time, and this is to the advantage of everybody who is a delegate to take seriously, I notice that a very nice arrangement was made for the delegate tables, they were given very hard seats, and I see a great many delegates sitting in the back where the chairs are better. I call that to the attention of the Committee on Arrangements.

DR. CRAWFORD: Mr. President, I would like to say that there will probably be a lot of things coming up next year, as I said yesterday, that we may not be able to tell you about except on short notice, and the only way that we can get these things across, the only way we got it across in the naturopath situation was at the grass roots level, and everybody did a lot of good work, and I hope if we call on you again you will do the same thing.

PRESIDENT SMITH: Thank you. The head teller is now about to make his report.

DR. WESTON: Mr. President, the result of the election for the Mediation Committee, Dr. Cook has been re-elected from the Second District, Dr. MacDonald has been re-elected from the Fifth District, and Dr. Tuten from the Eighth District.

PRESIDENT SMITH: Thank you, Dr. Weston. If there is no further business, I declare this meeting adjourned.

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BOOK REVIEWS

PROGRESS IN ARTHRITIS. J. H. Talbott, M. D. and L. M. Lockie, M. D. Grune & Stratton, New York. 1958. Price \$12.50.

A collection of short articles under the editorship of John H. Talbott and L. Maxwell Lockie. Largely devoted to rheumatoid arthritis, a number of the disorders now termed "collagen diseases" are included. Sections are devoted to rheumatic fever, gout, Dupuytren's contracture and the shoulder-hand syndrome. It is more than a review of progress, but rather an up-to-date statement of what is presently known about each disorder. Considerable attention is given to critical discussion of differential diagnosis and treatment. The articles are authoritative and full bibliographies are given with each. The book should be of considerable usefulness to anyone dealing with the rheumatic diseases.

John A. Boone, M. D.

TEXTBOOK OF MEDICAL TREATMENT. Edited by D. M. Dunlop, M. D., Stanley Davidson, M. D.;

S. Alstead, M. D. 894 pages; The Williams and Wilkins Company, Baltimore, 1958. Price \$11.00.

This is an English publication compiled by twenty-nine authors which has been written for the student and general practitioner as a quick reference to the treatment of a variety of disorders.

The text is extremely basic with statements such as, "The aim of disinfection is to destroy the germs released from a patient," plus a great deal of emphasis on rest, nursing care and symptomatic treatment. A tremendous scope is covered ranging from pediatrics to geriatrics which of necessity makes each disease covered very brief in outline. Tropical diseases and helminth infestations are covered in one chapter, interesting enough not including more common forms as seen in America such as hookworm, and this does afford a brief, ready form of reference. The National Health service and its relationship to British medicine is also discussed and is of interest though of no practical value.

This cannot be recommended as a text for the student but would be of value to a practitioner in looking up the therapy for infrequently seen diseases and the dosage schedules.

Charlton deSaussure



"hand-itis"
yes, any rheumatic "itis" calls for
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corticoid-salicylate compound
TABLETS

Schering

56-J-458

ORTHOPEDIC DISEASES by Ernest Aegerter, M. D. and John A. Kirkpatrick, Jr., M. D.; W. B. Saunders Co., Philadelphia, 1958. Price \$12.50.

This book is the happy result of collaboration of a pathologist and a radiologist in presenting the basic factors in the interpretation of diseases involving the musculo-skeletal system. Better diagnosis of orthopedic conditions is predicated upon an understanding of the pathology and physiology of bone and interpretation of roentgenograms. These are correlated in such a way as to make the book not only valuable to the orthopedic specialist, but also to the medical student. For clearer understanding and as a foundation for clinical material presented later on, the first part of the book reviews the anatomy and physiology of the skeletal tissues. The rudiments of pathology are presented as a brief review to allow better understanding of the more detailed studies of the pathological and radiological changes in the diseases presented in detail in the remainder of the text.

The main body of the book is divided into three sections having to do with disturbances in skeletal development, disturbances in the normally formed skeleton and tumors and tumor-like processes. There are many illustrations and photographs which are well chosen and which illuminate the text beautifully. It contains a wealth of material for the student or specialist which is presented in an unusual and very provocative way.

John A. Siegling, M. D.

THE MEDICAL MANAGEMENT OF CANCER. Henry D. Diamond, M. D., Published as one of Modern Medical Monographs, Grune and Stratton, 1958, 179 Pages. Price \$6.75.

This book comprises a complete and up-to-date summary of the current knowledge in regard to neoplastic diseases for which medical treatment should be employed. It is aptly divided into two sections: The first concerns those cancers in which the *primary* treatment is medical (non-surgical), and includes a discussion of the malignant lymphomas, the leukemias, and plasma cell myeloma. The second section is on the medical management of those cancers in which the primary treatment is surgical. The subjects discussed are neuroblastoma, cancer of the lung, thyroid, ovary, breast, and prostate.

Each disease is taken up in a well-outlined, orderly manner, with a discussion of etiology and incidence, pathology and natural history, diagnosis and pathologic physiology, treatment and end-results. An appendix on the intracavitary injection of radioisotopes was prepared by Dr. Richard Y. Card and Dr. Ulrich K. Henschke, and edited by the author.

Complete references are provided at the end of each chapter. An index makes this useful as a reference volume.

The author, who is Associate Attending Physician on the Medical Neoplasia Service at Memorial Center for Cancer and Allied Diseases, has drawn on a wide personal experience with the medical management of cancer and also has received able assistance and co-operation from his colleagues at Memorial Hospital and Cornell University.

In the past, the treatment of neoplastic diseases has been considered largely within the province of the surgeon and the radiologist. This volume provides a much-needed summary and reference source for internists, general practitioners, and all others who may, and should, treat neoplastic diseases from time to time. There is frequently an attitude of defeatism toward the treatment of those diseases in which the primary management is medical, but as pointed out by the author, the five-year survival rate for the malignant lymphomas far exceeds the survival rates for patients undergoing massive surgical treatment for carcinoma of the stomach, lungs, pancreas, malignant melanoma, osteogenic sarcoma, and Ewing's sarcoma of bone.

John C. Hawk, Jr., M. D.

GENERAL PATHOLOGY by Sir Howard Florey, Professor of Pathology, University of Oxford. Second Edition. W. B. Saunders Company, Philadelphia 1958. Price \$16.00.

Unlike other textbooks of general pathology this is not a complete or detailed review of disease processes and their manifestations in the various organs and systems. Rather the author has accumulated and edited a large group of carefully picked lectures from the course in general pathology and bacteriology at the University of Oxford. These lectures emphasize basic pathological principles and develop them by means of the experimental approach. Such processes as inflammation, thrombosis, antigen-antibody reaction and anaphylaxis are discussed and described as they are observed experimentally.

In the light of our present teaching program this is not a recommended text for the second year medical student. It is, however, an excellent supplemental text especially for the better students and residents or graduate students.

The material is presented in an interesting and readable fashion despite the fact that it often is quite detailed and complex. The illustrations, mostly black and white, are good and the entire arrangement is nicely done. This edition differs from the first mainly because of the addition of chapters on thrombosis and metabolic disorders following injury, atherosclerosis and tumors and some alteration in the sequence of the chapters.

I would recommend this book for selected individuals.

Edward E. McKee, M. D.

SAFETY IN BOATING

A record 7-million-plus boats—about one for every 25 people in the United States—are expected to take to the water this season.

This means that, more than ever before, common sense and safety will be required to keep the "pleasure" in pleasure boating.

"As we see it," says Vice Admiral A. C. Richmond, commandant of the Coast Guard, "education in the safe equipping and operation of boats is a fundamental necessity in keeping the casualty rate to a minimum.

"Too many of our people today are probably shoveling off for a spin in their powerboats with only the sketchiest of information concerning the proper operation of a motorboat, the rules of the road, overloading, lights, safety equipment, effects of weather."

Adding to this is the "discovery" by inland boat owners of many smaller waters where there are no Coast Guard stations or facilities, and where regulations and safety requirements are ignored.

One of the most common (and surprising) instances of disregard for boat safety is failure of many boat owners to provide each passenger (including children) with lifesaving equipment. The Coast Guard tests and inspects various types and materials and those that meet its specifications are certified "Coast Guard Approved."

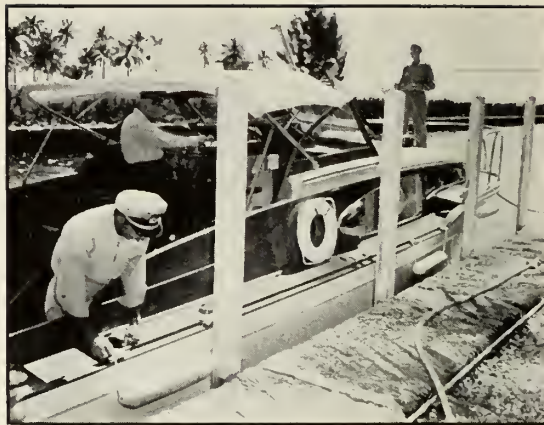
The Motorboat Act of April 25, 1940 requires that all motorboats, including outboards, carry one Coast Guard approved life preserver, buoyant vest, ring buoy or buoyant cushion in serviceable condition for each person on board.

Newest equipment to receive Coast Guard approval is a ring life buoy made of cellular vinyl plastic. Unlike other buoys that are filled with natural materials and covered with canvas, the one-piece vinyl rings will not rot, break or crumble. The Company which manufactures the rings for commercial and pleasure craft, states that they require no maintenance. The new rings are impervious to sun, sea water, oil or gasoline and are fire resistant.

Other types of approved lifesaving equipment include jacket life preservers, buoyant cushions and buoyant vests.

Overloading the boat is dangerous. In addition to reducing the operating efficiency and maneuverability of the boat, it's almost a sure bet that, in the event of an emergency, there will not be enough lifesaving equipment aboard for all passengers.

Fires and explosions are among the most common and often the most serious of boating mishaps. The Coast Guard points out that gas and oil vapors are heavier than air and consequently accumulate in the lowest part of the boat where they may not be readily detected. An open flame, lighted cigaret or electric spark can cause a serious explosion under these conditions. (A half pint of gasoline in the bilge may



CAREFUL ATTENTION to the details of keeping the boat shipshape and safe before going out will save headaches (and possibly lives) later. Make sure you carry lifesaving equipment for each passenger, as required by the Coast Guard, and that your boat is not overloaded.

create a potential explosive power of five pounds of dynamite.)

In order to reduce the danger of fire or explosion, the Coast Guard recommends extreme care with paints and varnish removers, the storing of waste and rags in metal containers or metal-lined lockers, and extreme caution during fueling and starting up after fuel has been taken on—all spillage should be wiped up completely. The use of gasoline stoves is not recommended, and gasoline should not be used for priming alcohol or kerosene burners or lighting coal, charcoal or wood stoves.

For maximum safety in equipment, owners should seek out products that are clearly labeled "Coast Guard Approved", being careful to make sure the complete product rather than part of it is approved.

Owners and passengers can be sure of smooth sailing by using common sense afloat and remembering the basic rules of boat safety.

10 BASIC RULES OF BOAT SAFETY

1. Keep bilges free from oil, waste, grease; fuel tanks ventilated.
2. Do not overload your boat.
3. Carry lifesaving equipment for every passenger.
4. Look where you walk; wear non-skid shoes.
5. Always carry a first aid kit and fire extinguisher.
6. Keep running lights in operating condition at all times; carry an extra flashlight.
7. Never use gasoline or flammable materials for cleaning.
8. Do not use gasoline stoves.
9. Have electrical equipment and wiring checked periodically.
10. Take your time when you are operating your boat or securing equipment and supplies.

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THE OPTIMAL DOSE OF DIGITALIS

JOHN A. BOONE, M. D., F.A.C.P.*

Nearly twenty years ago I read a paper on "Modern Usage of Digitalis" before the First District Medical Society in Walterboro, which was subsequently published in this journal.¹ If I were writing an article on the general subject today, I would hardly change a word of that thumbnail sketch.

Experience in the past twenty years, nevertheless, has convinced me that digitalis, in spite of being one of the oldest useful drugs we have, is still probably the most improperly administered one of all. This is, I think, a result of two factors: the failure of many physicians to realize how necessary it is to individualize both the initial dose and the maintenance dose for each patient, and the fact that the endpoint of proper dosage is often not a clear-cut sign, such as the disappearance of sugar in the urine when treating a diabetic patient with insulin.

That the wide variability in digitalis dosage requirements is not generally appreciated was emphasized recently by Levine and others.² They stated that "... the process of digitalization should be thought of as an individual biological titration". This is a modern and more scientific-sounding rephrasing of William Withering's original directions that the drug be given until the patient got better or developed signs of poisoning.³ To quote from my own paper of twenty years ago: "With reference to the dosage of digitalis, the need for

individualization in each patient cannot be too strongly emphasized. While in any one patient the required amount of digitalis varies somewhat in proportion to the degree of congestive failure, patients will vary a great deal among themselves as to the actual amount required to produce a given therapeutic effect".

The experience of twenty years has brought the observation that whereas the common error with the older preparations of digitalis leaf was underdosage, the newer purified, accurately standardized and potent glycosides have caused more bizarre pictures of digitalis poisoning than I ever saw before their introduction. Drug salesman promoting these newer preparations often claim they are less apt to produce nausea than the older whole leaf. This may be true in occasional cases and may be responsible for more frequent overdosage, but I have seen some patients who sustained marked loss of true body weight from the anorexia caused by chronic overdosage with the newer preparations.

I shall try to outline the rules for proper use of digitalis in common situations where it is indicated and illustrate these rules as far as practicable with summaries of actual cases.

Auricular Fibrillation

Auricular fibrillation is most commonly seen as an event in the course of organic heart disease, although it rarely occurs as a functional arrhythmia in normal persons and more frequently during the course of hyperthyroidism in persons with normal hearts. I have also seen it in paroxysmal form in several persons who had taken desiccated thyroid for years either

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for weight reduction or with a mistaken diagnosis of hypothyroidism. The onset of auricular fibrillation is usually accompanied by a rapid, inefficient ventricular beat, and frequently is the precipitating cause of congestive heart failure.

It is here that digitalis has its clearest indication and most spectacular effect, and proper dosage is most easily achieved. The drug is given rapidly in sufficient dosage to slow the ventricular rate to about 70 beats per minute at rest, and the maintenance dose is the amount that will keep it there. The improvement in the patient is spectacular because the drug is simultaneously exerting two beneficial effects: the ventricle is made to contract more efficiently, and the rapid, exhausting ventricular beat is slowed down by a certain small increase of the block at the auriculoventricular node. Fortunately, optimum effect in both these directions is usually had by the same dose of drug, so the ventricular rate can be used as a clear end-point for adjusting dosage.

To be accurate, counting the ventricular rate must be done after the patient has remained at rest for at least 15 minutes, and must be done by listening to the heart, rather than by counting the radial pulse (the weaker ventricular beats do not get through to the wrist, and a falsely low ventricular rate may be inferred). Moreover, the counting must be done by the doctor. Whatever their other sterling qualities may be, I have encountered relatively few nurses who were able to count accurately an irregular pulse, and of course, their training in auscultation is minimal.

There are some exceptions to the above simple rule that should be watched for and correctly interpreted. Some patients in severe failure may require what seems an inordinate dose of digitalis to bring the ventricular rate down to 70. As long as the rate is still grossly irregular but slowing down, one may be reassured that still more digitalis is needed, but one should have an electrocardiogram to make sure that the rhythm is still auricular fibrillation and has not changed to ventricular tachycardia or auricular tachycardia with block—both of which are grave manifestations of deep intoxication with digitalis.

An occasional heart may be observed to have become regular following a large dose of the drug. An electrocardiogram will then be necessary again to show whether the heart has simply reverted to a normal sinus rhythm, or has developed complete heart block with a relatively rapid ventricular rate from digitalis overdosage.

Occasionally it will be found that the ventricular rate in auricular fibrillation, rather than slowing with digitalization, becomes more rapid, perhaps with increase in ventricular premature beats, and even the nausea and visual disturbances of obvious digitalis toxicity may appear while the ventricular rate is still climbing. This train of events almost invariably means hyperthyroidism—and the latter may be so occult that diagnostic tests will fail to prove it. But the response to treatment of hyperthyroidism proves the diagnosis:

A 45 year old man with the Eisenmenger complex proved at cardiac catheterization had developed auricular fibrillation and uncontrollable failure. Attempts to slow his very rapid ventricular rate with digitalis resulted only in the appearance of multiple ventricular extrasystoles and no slowing of rate or improvement in his failure. Repeated tests of I^{131} uptake and serum protein-bound iodine were within the normal range. Administration of propylthiouracil was followed by marked slowing of ventricular rate and decrease in failure. Ablation of the thyroid by I^{131} resulted in persisting ease of slowing of the ventricular rate with digitalis and the failure has since been easily controlled.

Once in a while a patient with auricular fibrillation will show a slow or not very fast ventricular rate before digitalis is given, because of a previously existing partial block at the auriculo-ventricular node. This may lead to either underdigitalization or overdigitalization:

A 78 year old lady at a routine examination had an electrocardiogram which showed a P-R interval of .24 second. Some two years later she developed early symptoms of congestive failure, and was found to be fibrillating, with a ventricular rate of 80. She was given 1.2 mg. of crystalline digitoxin (Purodigin), followed by 0.1 mg. daily. When I first saw her the ventricular rate was 50 per minute at rest. She complained of persistent anorexia which had reduced her weight 15 pounds below what she had ever been able to achieve by diet, and commented on pretty purple flowers in a field where her companion could see none. Her drug was stopped and after 10 days her

appetite returned and the ventricular rate had risen to 70 per minute. She has since been maintained *in statu quo* on 50 mg. of digitalis leaf daily. Although she was fibrillating, her heart had probably been protected from the exhaustion of a rapid rate by her "built-in block", but she happened to require just half the usual amount of digitalis, and had been well poisoned by the usual dose administered to such a patient.

A 40 year old man with mitral stenosis and auricular fibrillation was admitted to the hospital for operation on his mitral valve. He had been taking 0.1 Gm. of digitalis leaf for several years, and at rest his ventricular rate was 50 per minute. He was thought to be overdigitalized and digitalis was not given for two days before operation. Just before anesthesia was induced (but following the usual dose of preoperative atropine), I received a call to the operating room where the patient was found to have increased his ventricular rate to 120 per minute, though still fibrillating. After a total of 0.8 mg. of intravenous lanatoside-C, his ventricular rate slowed to 70 and operation proceeded with a successful valvulotomy. When seen in the Heart Clinic one month after operation, he said he had taken no digitalis since discharge, and his ventricular rate was still grossly irregular at 50 per minute. Obviously, the man had a "built-in block" which operated to keep his ventricular rate down until abolished with preoperative atropine, and he had probably never been fully digitalized until the day of his operation.

A final warning is in order before depending on slowing of the ventricular rate as an end-point in controlling auricular fibrillation with digitalis. It was stated above that the ventricular rate must be counted after a 15 minute rest, and also that frequently it could not be slowed with the drug in hyperthyroidism. This is because anything that increases the patient's metabolism will prevent his ventricular rate from slowing to 70 even with adequate dosage of digitalis. It must be remembered that infections will also increase the patient's metabolism, and care should be taken not to overdose those with auricular fibrillation who are concurrently suffering from pneumonia or other infections. This point is well illustrated in the case described in the section to follow.

Congestive Heart Failure With Regular Rhythm

It is in the group of patients who have congestive failure and normal sinus rhythm that proper dosage seems most often to elude the physician. Here one must depend on finding a dose short of producing toxic symptoms, yet

sufficient to alleviate signs and symptoms of failure. On the *average*, the patient will be digitalized by one "cat unit" of digitalis preparation per ten pounds of body weight spread over one or two days, and the digitalization will be maintained by one cat unit daily thereafter. But the *average* dose will be tried on some patients for whom it is too much, and on many for whom it is inadequate.

I prefer when trying to determine a patient's digitalis requirement to delay the use of diuretics and sodium restriction wherever possible and to watch the patient's body weight, which will drop sharply from digitalis diuresis when the proper level is reached in his body. I first give him the average cat unit per ten pounds of body weight and stop to see whether he is showing toxic symptoms or whether his symptoms have improved.

If he is showing toxic symptoms, several possibilities should be considered:

- (1) The diagnosis of congestive heart failure may have been incorrect.
- (2) He may have been given digitalis recently without being aware of it.
- (3) He may be one of those occasional individuals who require a smaller than normal dose. Further management will depend on which possibility is found to be correct. At this point it should be emphasized that when a patient has been made toxic with digitalis the dose should *not be reduced*, but the drug *stopped* until toxic symptoms have disappeared and then resumed in smaller dosage. The slow elimination of digitalis (averaging about 1 cat unit per day) will prolong unduly the toxic symptoms if the dose is merely reduced.

If the patient's dyspnea has improved and his body weight dropped through loss of edema, he may be assumed to be digitalized and thereafter placed on the average maintenance dose of one cat unit daily. He may need diuretics and sodium restriction to effect complete loss of edema, or not, and these may then be utilized if necessary. If the initial average dose is not followed by improvement in dyspnea and loss of weight, digitalis should be pushed further. This may be done by giving digitalis at the rate of three cat units daily

while observing the patient at least once daily, or if he can be observed closely in the hospital, at the rate of three cat units every four hours, examining him before each dose for evidence of improvement or toxicity. When full digitalization is achieved, the size of the probable maintenance dose can be then inferred from the relative amount required to achieve it. Further experience will prove whether this dose must be adjusted up or down, just as one would not turn a diabetic loose with an invariable dose of insulin. In the cardiac patient, the doctor's eyes, ears and horse sense must serve the same purpose as the diabetic's test of his urine for sugar.

Persistent anorexia and the appearance of an irregular heart beat are the most dependable symptoms of overdosage. But anorexia is a symptom that must be evaluated correctly in a patient who knows his heart is failing. And extrasystoles may occur in heart failure but be diminished or abolished by proper digitalization.

I shall terminate this discussion with the summary of a case of mine that over a period of years has been instructive to both myself and a number of my resident physicians in the paths and bypaths of managing a case of congestive heart failure as he slowly goes downhill.

A 56 year old man was referred to me in 1948 for treatment of severe congestive heart failure accompanied by auricular fibrillation. He had had a thoraco-lumbar sympathectomy a few years before for Buerger's disease. He had already received an unknown amount of digitoxin from his local physician. On examination he showed a moderately enlarged heart, auricular fibrillation with a ventricular rate of 110 per minute, pulmonary congestion and peripheral edema. He was given 0.4 mg. of digitoxin and the following morning his fibrillation had reverted to a normal sinus rhythm, his dyspnea had greatly improved and diuresis had begun. He was placed on 0.2 mg. of digitoxin daily and improvement steadily continued. On discharge a roentgenogram of his heart showed marked reduction in size. He returned for an office visit two months later. His improvement was maintained and the heart had returned to normal size by x-ray measurement.

On continuation of his digitoxin dose and limitation of physical activity he did well, with no further signs or symptoms of failure, for a period of seven years, when he had an attack of pulmonary edema following a little unusual physical activity. When placed in the

hospital following this, he showed no changes except for a slight increase in heart size by roentgenogram. He was discharged on the same 0.2 mg. dose of digitoxin.

Again he did very well but was referred to me again eight months later because of a persistent cough following a virus infection. Slight further increase in heart size and a little pleural fluid were found. His digitalis dosage was increased slightly for two days and one dose of a mercurial diuretic was given, resulting in loss of five pounds in weight and clearing of his pleural fluid, and he was discharged, again on 0.2 mg. of digitoxin daily.

Three weeks later he was readmitted because of repeated attacks of paroxysmal nocturnal dyspnea. This time his digitoxin dosage was increased to 0.2 mg. three times daily for one week and then stabilized at 0.4 mg. and 0.2 mg. on alternate days. Pulmonary congestion cleared and his nocturnal dyspnea ceased, although no diuretics were given. His electrocardiogram on this dosage showed a slight degree of A-V conduction delay.

He did well on this regime for a period of eight months, when he "went through the clinic" at a medical center in another state. He was told there that he was taking too much digitalis and his dose was cut back to 0.2 mg. of digitoxin daily. Two weeks later he was again sent to us with a resumption of his attacks of paroxysmal nocturnal dyspnea and the appearance of edema of the ankles. On this occasion bilateral thoracentesis was necessary and 3,000 ml. of fluid were removed. He failed to respond to mercurial diuretics. Shortly after admission auricular fibrillation developed. Digitoxin was pushed until his resting ventricular rate reached 70, whereupon his edema cleared. He was discharged on 0.3 mg. of digitoxin daily and his physician was advised to adjust this as necessary to maintain a ventricular rate of about 70.

He was again seen here four months later with a chief complaint of persistent anorexia, nausea and vomiting. Some six weeks before, following an episode of viral pneumonitis, his pulse rate had increased, and in an attempt to control it he had been given 0.8 mg. of digitoxin daily for three weeks. He appeared to be in an excellent state of compensation, but the electrocardiogram showed auricular fibrillation with complete A-V dissociation and a rapid ventricular rate—a sign of severe digitalis toxicity. Withdrawal of all digitalis resulted in a few days in disappearance of the A-V dissociation and resumption of auricular fibrillation with a ventricular rate of 70. The nausea and vomiting similarly disappeared. It was then determined that maintaining a ventricular rate of 70 required a daily dose of 0.6 mg. of digitoxin. The patient has remained on the maintenance dose of 0.6 mg. of digitoxin at the present writing for nine months without symptoms or signs of either congestive failure or digitalis toxicity.

This patient illustrates the slowly increasing dosage of digitalis necessary to control congestive failure over a period of about 10 years in the same patient. Several of the common pitfalls are also illustrated. First, we were somewhat slow in recognizing that his dosage needed to be increased. Second, an erroneous diagnosis of digitalis toxicity was made at a famous medical center. Third, the ease of maintaining correct dosage after onset of auricular fibrillation is seen. Fourth, the effect of increased metabolism (fever) in speeding up his ventricular rate led to his only episode of digitalis poisoning. And fifth, he has lived for nine months in comfort on a daily dose of

digitoxin (0.6 mg.) which many physicians would immediately label as out of all reason and poisonous. But for this man 0.8 mg. is poisonous, and 0.6 mg. is just right.

It is hoped that this discussion will be of some help to the physicians of South Carolina in determining the proper dosage of digitalis for their patients.

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METABOLIC ALKALOSIS WITH KALIOPENIC NEPHROPATHY

R. RANDOLPH BRADHAM, M. D.* AND CHEVES McC. SMYTHE, M. D.**
Charleston, S. C.

Recently a young man was admitted to the Medical College Hospital with severe protracted vomiting secondary to pyloric obstruction. His case is presented as an unusual example of fluid, electrolyte, and acid-base imbalance with a discussion of the effect of these abnormalities on the kidney. The fluid volume deficit was as severe and the serum electrolyte concentrations were the lowest observed by us in a patient who survived. He demonstrated many of the signs and symptoms associated with metabolic alkalosis.

A 36 year old colored male, was admitted to the Medical College Hospital on April 2, 1958 because of pyloric obstruction. A duodenal ulcer had been demonstrated 17 years before (in 1941) by roentgenogram. Symptomatic response to diet, antacids, and methantheline bromide (Banthine) was good at that time. This program was followed intermittently, and the patient continued to get along well until 1950 when he entered the hospital for recurrence of symptoms and a minor hemorrhage requiring one blood transfusion. One month before the present admission, he began having abdominal pain, nausea, and vomiting. The vomiting was at first infrequent but pro-

gressed in frequency and severity. During the week before admission he retained nothing but continued to take fluids and ice cream, only to vomit them 30 to 60 minutes later. Epigastric cramping pains were persistent and not relieved by Banthine and antacids. He had not had a bowel movement in one week and had not voided for 24 hours before coming to the hospital. He had become extremely weak and dizzy.

On physical examination he was found to be a severely ill and dehydrated young man who had lost a great deal of weight. Skin turgor was poor, and the skin was warm and dry. Mucous membranes were dry. The eyes were moderately sunken. Peripheral veins filled poorly. Blood pressure was 100/80, pulse 100/min., and respirations 20/min. and shallow. The pupils reacted well to light. The abdomen was scaphoid and not tender. Peristalsis was present. No organs or masses were palpable. The sensorium was clouded and the patient was extremely weak. Muscle weakness was a prominent finding. Reflexes were markedly hypoaactive.

Hematocrit on admission was 54%. No urine could be obtained for urinalysis. However, the urine showed 3+ albumin 36 hours later and 2+ three days after that. The blood urea nitrogen was 94 mg. per 100 ml., serum chloride 45.6 mEq/l., and CO₂ combining power 150 vols. per cent, (67.5 mEq/l). Sodium and potassium on the following morning were 131.8 mEq/l. and 2.56 mEq/l. respectively. These values were obtained following administration of solutions containing both of these electrolytes.

From the Departments of Surgery and Medicine, Medical College of South Carolina.

* Assistant Professor of Surgery.

** Assistant Professor of Medicine and John and Mary R. Markle Scholar in Medicine.

Table I
Laboratory Determinations

	April 2 8 P. M.	April 3 8 A. M.	April 3 7 P. M.	April 4 8 A. M.	April 4 8 P. M.	April 5	April 6	April 10
Cl (mEq/l)	45.6	54.1	54.1	74.3	99.7	104.8	103.1	108.2
Na+ (mEq/l)		131.8		121.8		144.3		156.5
K+ (mEq/l)		2.56		2.77		4.97		5.95
CO ₂ (vols. %)	150		78	138	115	90	80	56
BUN (mg. %)	94			126		83	87	40
VPC (%)	54						33	34

The working diagnosis was duodenal ulcer with pyloric obstruction and severe hypochloremic, hypokalemic alkalosis associated with renal tubular damage secondary to potassium depletion (kaliopenic nephropathy). Subsequent serum electrolyte studies are given in Table I.

Course of Therapy

The severity of the deficits of intracellular and extracellular fluid volume and electrolytes was obvious on admission. It was equally apparent that administration of electrolytes would probably not raise the serum values initially until some of the total body deficiencies were corrected.

Fluids and electrolytes during the first 24 hours in order given were as follows:

	Na	Cl	K
2000 ml. 5% dextrose in 0.9% NaCl.	308	308	
1000 ml. 10% dextrose in DW with 40 mEq. KCl			40
1000 ml. Lactated Ringer's solution	130	109	4
1000 ml. 10% dextrose with 40 mEq. KCl			40
1000 ml. Lactated Ringer's	130	109	4
1000 ml. Lactated Ringer's with 80 mEq. KCl	130	109	84
300 ml. 3% NaCl.	165	165	
7300 ml. Totals	863	800	172

There was some hesitation about administering large quantities of potassium initially although it was suspected that a large potassium deficit existed. The anuria was believed to be on the basis of dehydration but could well have been on the basis of renal damage caused by electrolyte imbalance. Fortyfour mEq. of K+ were actually given before urine flow began as the patient continued to be anuric until the fifth liter was being infused. At the end of 24 hours volume replacement was adequate but electrolyte deficits, although improved, were still large. The patient became more responsive and his sensorium began to clear. Muscle weakness and hyporeflexia were still present. The blood pressure had improved to 156/85. Pulse remained 112/minute.

During the second and third 24 hour periods the following electrolyte solutions were given. He was begun on small amounts of milk on the third day.

By reference to table I, it can be seen that at the end of 72 hours electrolyte balance was being accomplished and the next morning, serum electrolyte determinations indicated that circulating deficits had been replaced. However, the high CO₂ combining

power of 90 vol. per cent indicated that the patient was still alkalotic and that even though serum potassium was normal, tissue deficits of this cation might still be present. The patient appeared well hydrated and his general physical condition improved rapidly. The sensorium cleared, and he was able to sit up on the side of the bed without help.

The pyloric obstruction persisted. His course was further complicated by bilateral thrombophlebitis of the lower extremities. In spite of the patient's condition, the pyloric obstruction had to be relieved so

Second 24 hour period

	Na	Cl	K
1000 ml. Ringer's solution	147	156	4
1000 ml. Lactated Ringer's with 80 mEq. KCl	130	109	84
500 ml. 2.14% NH ₄ Cl		200	
300 ml. 3% NaCl	165	165	
1000 ml. Lactated Ringer's in 5% dextrose with 80 mEq. KCl	130	109	84
3800 ml. Totals	572	739	172

Third 24 hour period

	Na	Cl	K
1000 ml. Lactated Ringer's sol. in 10% dextrose with 40 mEq. KCl	147	156	44
1000 ml. 10% dextrose with 40 mEq. KCl			40
2000 ml. Totals	147	156	84

that he could begin oral nourishment. Gastro-enterostomy was elected, because it was the simplest and shortest procedure which could be done in this debilitated patient. This was carried out without difficulty on the eighth hospital day. Oral intake was begun on the third postoperative day and the diet progressed to six feeding bland diet. Recovery was rapid and he was discharged on the ninth postoperative (17th hospital day) day. Weight gain was rapid following discharge and he returned to work three weeks after the gastro-enterostomy had been done.

Discussion

This case demonstrates many interesting aspects of fluid and electrolyte imbalance. First of all the degree of deficiencies which existed make this a most unusual case. Their magnitude is indicated by the initial serum electrolyte determinations and also the total quantities of each electrolyte which were necessary to replace the individual deficits. The correla-

tion between the improvement of the patient's physical and mental status with that of replacement of fluid and electrolyte losses shows well the importance of physical examination and the constant observation necessary in treating any patient who has a severe fluid or electrolyte problem. The defenses of the body maintained a serum sodium concentration high enough to prevent circulatory failure although the total body sodium was low. Compensation for the chloride losses was maintained largely by retention of CO_2 which resulted in the severe alkalosis. Since his deficits had accumulated slowly over a long period, their correction could not be rapidly effected. His losses were of water, electrolyte, and protein. Replacements were also accomplished in that order.

The individual with chronic vomiting loses at first an acid gastric juice with some sodium and relatively little potassium in it. However, if vomiting persists long enough, the hydrogen ion in gastric secretions is replaced by sodium and potassium.¹ Therefore, a patient such as this is deficient not only in water, chloride, and hydrogen ion, but also severely so in sodium and potassium. The characteristic serum electrolyte pattern is one of very severe metabolic alkalosis (column 1, table 1).

Although his blood pressure was 100/80 mm. of mercury, the patient was anuric on admission. The blood urea nitrogen was 94 mg. the next day, and the urine contained significant amounts of albumin. At first glance this renal lesion might be considered only the result of dehydration or so-called prerenal azotemia. However, it is striking that the blood urea nitrogen remained elevated despite adequate urinary outputs for at least ten days after repair of his volume deficit. Also, his urinary specific gravity remained low in the face of severe dehydration.

This patient then had a renal lesion in addition to the functional disturbance created by his fluid loss. The severe potassium deficiency and the alkalosis indicate that this was the nephropathy of potassium depletion which has been clearly described both clinically and experimentally in the past two years.² The role of potassium in renal function is be-

coming more evident. Berliner³ has described secretion of potassium by the distal tubule which changed materially previous concepts of renal handling of the electrolyte. This was followed by enough evidence that hydrogen ion and potassium secretion were correlated to suggest that these two functions were competitive. Relman and Schwartz² have described a syndrome in man marked by potassium depletion, polyuria, polydipsia, loss of concentrating ability, minimal increase of blood nitrogen levels, and decreases of inulin and para-amino-hippurate clearances. All of these changes are reversible upon potassium repletion. Histologically, the lesion consists of vacuolization of tubular epithelial cells. Roughly, the same spectrum of clinical, laboratory and histological changes has also been described in hyperaldosteronism, one of the hallmarks of which is severe potassium depletion.⁴ The same lesion both physiologically and pathologically can be produced in potassium depleted rats.⁵ The degenerative changes are histologically relegated to the distal tubule where the active potassium exchanges mentioned above occur and where modern theory places the concentration of urine.

In addition to the loss of concentrating ability these patients all have a metabolic alkalosis, a high serum partial pressure of CO_2 , an acid urine (so-called paradoxical aciduria), a high threshold for bicarbonate, increased excretion of hydrogen ion and relative renal conservation of sodium. Many of these changes are thought to be due to a lack of potassium for distal tubular secretion or exchange which is a partial determinate of bicarbonate loss and hence of the plasma partial pressure of CO_2 and of the high hydrogen ion excretion (the reason for the acid urine).

The major therapeutic implication in a patient such as this is that normal electrolyte balance cannot be attained without replacement of the large body potassium deficits. This patient received 428 mEq. of potassium (17.1 gm. of potassium or 32.8 gm. of potassium chloride) in his first 72 hours in the hospital. At the end of this time he was excreting only 0.3 grams of potassium in his urine for 24 hours or only 8 mEq. By the following day the

deficit had been only partially corrected in that potassium excretion rose to 55 mEq. a day in spite of the infusion of 84 mEq. It is also striking that not until his eighth day did the alkalosis disappear and that his blood urea nitrogen remained elevated for eight days despite a daily urine output of over 2 liters a day. This is evidence that the renal tubular lesion took at least ten days to heal. It has also been suggested that patients with severe alkalosis do not tolerate anesthesia and are prone to develop ventricular fibrillation when anesthetized.

This patient was as severely depleted as one can be and yet survive. His essentially uneventful course was in large measure dependent upon clear realization that fluid and electrolyte losses had to be restored before his underlying disease could be treated surgically. Patience is required in the restoration of chronically depleted states, and the wisest course is to wait for complete repletion before surgery is undertaken in the elective situation.

Simple posterior gastro-enterostomy is not the operation of choice for chronic duodenal ulcer. It was elected in this patient because of his emaciation and poor nutritional status with the idea that either sub-total gastrectomy or vagotomy would be done at a later time.

Summary

The case of a young colored male who de-

veloped severe metabolic alkalosis and dehydration because of pyloric obstruction is reported. Initial laboratory determinations revealed marked deficits of serum electrolyte concentrations and evidence of renal damage. The problems of replacement of fluid, electrolytes, and protein are discussed and course of therapy outlined. The response to therapy was depicted in the improvement of the patient and restoration of serum electrolyte concentrations. The mechanism of loss of each electrolyte and subsequent development of metabolic alkalosis is given. Renal damage was based on the findings of albuminuria, a low urine specific gravity, and elevated blood urea nitrogen lasting ten days. The association of potassium depletion and renal damage, the reversibility of this process by potassium repletion, and the microscopic and physiologic effects of potassium depletion on the renal tubule are discussed.

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Changing Characteristics of Society—Report of Workshop Conference. Julian P. Price, M. D., Florence, S. C., Russell A. Nelson, M. D., Baltimore and W. Clarke Wescoe, M. D., Kansas City, Kan. *J.A.M.A.* 167:49 (May 3, 1958)

"We are convinced that no other profession is as profoundly introspective as medicine, a profession that has given so much and promises to give even more. There appears to be general agreement that American medicine has reached a point never before approached by any system, that American medical education has reached a pinnacle. Yet intensive soul-searching and thought of necessity continue. We are not convinced that the general public is aware of this. We are not convinced that the public appreciates that medical schools decry so-called premedical curriculums; that medical schools prefer those preparing themselves for admission not to segregate themselves from their fellows at an early period in college. We are not convinced that the general public appreciates that medical schools encourage a broad liberal arts

education, that they have places for majors in history and sociology as well as in chemistry, that they have reduced their specific requirements in order to allow for this broadened collegiate education. We are not convinced, further, that the general public is aware of the fact that medical schools are stressing the behavioral sciences and social aspects of illness. We believe that the general public must be made aware of these matters.

Further we believe that in some way the public must be educated to know better the role of the physician in order that his energies may best be conserved and his abilities most efficiently used. In many areas the public has come to know that the time the doctor has to spend in his car is wasted as medical service; further it has come to appreciate the fact that the physician can operate more efficiently in his office or clinic facility than at the bedside in a home. If this educational process can continue, our medical talents will be put to better use—more will be served by fewer physicians."

BIG BREASTS

CLINICAL PROBLEMS AND MANAGEMENT

ROBERT F. HAGERTY, M. D. AND FORDE A. McIVER, M. D.^o

Large breasts may be a cause of physical discomfort, a site of pathological change threatening health or life itself, and a source of mental distress. It is our purpose to outline the problems related to large breasts and to propose a method of management in selected cases which offers the greatest degree of safety combined with a reasonable aesthetic result.

Physically, excessive mammary bulk frequently produces a chronic aching sensation of the back, neck, and chest because of the dragging weight. This commonly leads to a stooped posture with rounded shoulders even in the very young with mammary hyperplasia. Chafing of the coapted skin surfaces beneath the breast often leads to dermatitis, maceration, and excoriation, especially in a warm, humid climate. The very size and weight of the breasts frequently interfere with athletic activities.

A hazard to health may be inherent in breasts whether they be large or small. Approximately one in twenty women will develop carcinoma of the breast,¹ the most common malignant growth in the female. The only defenses against this disease are early diagnosis and treatment. The palpation of a discrete nodule by the patient or her examining physician is usually the first step in diagnosis. Although the vast majority of palpable breast masses are benign, benignancy cannot be safely established in discrete nodules without histological examination. In some individuals, repeated biopsies must be carried out, each with its attendant risk. In addition, fibrous tissue introduced with each surgical exploration makes detection of significant changes by future palpation more difficult. Palpation of the abnormally large breast is unsatisfactory under any conditions but the addition of further scarring compounds the problem. Be-

nign breast lesions are known to be associated with malignancy, some studies suggesting an abnormally high rate of malignant change in mastoplasia² (chronic cystic mastitis). Although bilateral simple mastectomy is believed to be rarely justified for benign breast disease, many surgeons feel that there is a limit to the number of biopsies which should be carried out in any given patient with a suspicious breast lesion or strong familial history of mammary carcinoma. Because of the increasing incidence of carcinoma of the breast with age, the indications for total mastectomy for symptomatic breast enlargement are greatest at a time when psychologic objection to this procedure is less acute.

Mental distress encountered in patients with large breasts is related to appearance and to a fear of cancer. The mammae may be of a distorted pendulous shape with striae and greatly enlarged areolae (Fig. 1). In addition,



Figure 1

Colored female, age 15. Juvenile hyperplasia of breasts.

their bulk may give rise to difficulties of proper dress and appearance. Theropy and nodular quality frequently encountered in large breasts naturally arouses concern in the patient who has been instructed in the early diagnosis of cancer. Biopsy, when indicated, cannot be omitted but each repeated experience carries with it a significant measure of psychic trauma and financial burden.

Conventional Methods of Management

The most conservative method of management of physical discomfort consists of at-

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tention to personal hygiene and support of the breasts by a properly fitted and designed brassiere. Such care will give relief of symptoms in a large number of cases. With the more difficult problems, however, these measures provide at best but partial relief. Shoulder straps may give rise to uncomfortable binding and especially in a hot, humid climate intertrigo may be unavoidable.

The conservative management of pathological changes includes frequent examination and adequate biopsies. The success of this approach will be proportional to the adequacy of physical diagnosis. The difficulties associated with the palpation of abnormally large breasts have been referred to. The need for repeated biopsies may be anticipated. In a series of 147 patients with cystic disease followed for 10 years or more by Haagensen, one-third developed further cysts, two-thirds of these being in the opposite breast.³ In one series of 510 patients with fibroadenoma, a second fibroadenoma was removed in 12.2 percent of the cases.³

The most conservative management of psychic disturbances includes those measures recommended for physical discomfort, the choice of clothing aimed at camouflaging the breast mass, and all possible reassurance after careful examination.

The conventional mammaplasty with the preservation of segments of breast tissue provides adequate relief from the physical discomforts associated with abnormally large breasts. This method does not, however, eliminate the possibility of development of pathologic changes in the remaining breast parenchyma and may, actually, increase the difficulties related to differential diagnosis by the introduction of scar tissue in the operative field.

With regard to the psychic aspect of the problem, conventional mammaplasty, when successfully performed, offers the best available solution to the concern over breast contour. Cancerophobia, on the other hand, is not dispelled by this approach and the resultant subsurface scarring, even though not distressing on inspection, may continue as a palpable source of worry.

Simple mastectomy is the most radical conventional approach to the problem of abnormally large breasts and it offers a complete solution to the difficulties related to physical discomfort, to the problem of prophylaxis against future development of breast disease, and to concern over the development of cancer. The great objection to this method of management is the fact that it makes no provision whatsoever for the patient's normal regard for personal appearance or for the psychic importance of the breast as a measure of sexual identity.

The Proposed Method

The ideal solution to the problem outlined would be a procedure which offered the physical relief and prophylactic value of a simple mastectomy, the cosmetic appearance of a mammaplasty, and the combination of psychology values outlined for both methods. At present, no such solution is available, but the method to be described does provide for com-

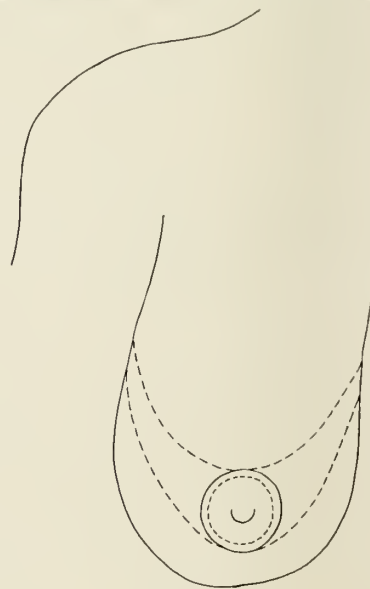


Figure 2

Dotted lines indicate skin incisions from midlateral to midmedial points and also for nipple and areola free graft.

plete removal of the breast mass and parenchyma and, yet, preserves all that is possible for the desirable breast contour and appearance. A better shaped breast can be produced with the conventional mammaplasty than with the technique proposed, which,

therefore, will have no appeal to the patient whose sole interest in seeking assistance is one of vanity. This method offers all of the prophylactic value and relief from cancerophobia provided by simple mastectomy but it retains the psychic support of a more normal appearance. This procedure will have no application for the occasional patient who may have a total disregard for the presence of her breasts.

Operative Procedure

The operative procedure as originally described by Mahiniac⁴ consists of elevating superior and inferior flaps of skin and subcutaneous tissue extending from the areola to the midmedial and midlateral breast points (Fig. 2). The nipple and the areola are re-

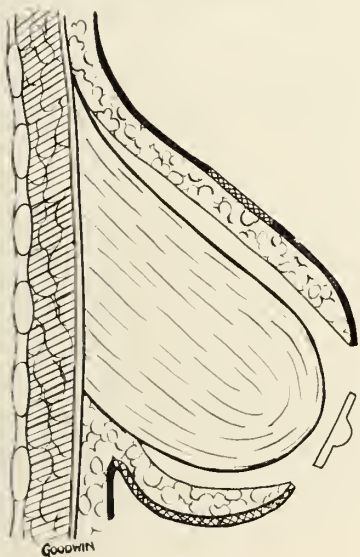


Figure 3

Elevation of skin and subcutaneous tissue flaps preparatory to meticulous resection of all breast tissue. The cross-hatched area on upper flap indicates site of preparation to receive free graft of areola and nipple. The cross-hatched area of lower flap indicates epidermis removed over area to be covered by superior flap.

moved as a free graft and the breast resected in its entirety (Fig. 3). The inferior breast flap is denuded of its superficial epithelial covering and is sutured superiorly to the pectoral fascia. The superior flap is in turn brought inferiorly over this underlying flap and sutured to its base. The areolae and nipples are sutured into their appropriate positions as free grafts (Fig. 4). The superimposed flaps of skin, which were greatly thinned and



Figure 4

Final position of upper and lower flaps with areola-nipple graft in place.

stretched by the large breasts, fill out with a remarkable amount of fatty tissue giving adequate, though rather flat, contour. Illustrative cases are shown in Figures 5 and 6.



Figure 5

White female, age 37. Upper photos preoperative. Lower photos, two years postoperative.

This patient had a 13 year history of gradually enlarging painful breasts associated with a dragging sensation over both shoulders. A sister had carcinoma of the breast.

Examination revealed large, heavy, pendulous breasts, the right considerably larger than the left. Their elevation by the examiner completely relieved the dragging sensation and made respiration easier. There were no nodules palpable and no nipple discharge was present.

Total mastectomy with reconstruction of breast contours using skin flaps and free nipple grafting was carried out on January 17, 1956. Histologic examination of the specimen revealed mastoplasia.

The patient was well satisfied with the procedure and remains asymptomatic.



Figure 6

White female, age 35. Upper photos, preoperative. Lower photos, three years postoperative.

This patient complained of chronic pain and soreness of the breasts together with a clear serous discharge from both nipples.

Examination revealed large, heavy, pendulous breasts of aropy consistency with no discrete nodules. A clear discharge from both nipples was present.

In March, 1955, total mastectomy and reconstruction with breast flaps and free nipple graft were carried out. Histologic examination showed only mild duct dilation and retained secretions.

The operative procedure proved satisfactory to the patient, with complete relief of symptoms.

Conclusions

1. Large breasts may be a source of physical and mental discomfort and a site of pathologic change of serious import.
2. In selected cases mastectomy may be recommended because of these difficulties.
3. The operative procedure proposed presents the disadvantages associated with any major

surgical procedure and leaves a relatively small breast contour and an insensitive nipple.

4. The proposed method offers the advantage of preservation of a partial breast contour with nipple and areola, the relief of symptoms related to excessive size and weight, and elimination of the danger of benign and malignant breast changes.
5. The advantages of the proposed method of management warrant its serious consideration in properly selected cases.

Summary

The clinical and pathological problems associated with large breasts are discussed and conventional methods of management are reviewed. A surgical procedure is proposed for selected cases which removes all breast tissue but preserves nipples, areolae, and a small but satisfactory breast contour. The advantages and disadvantages of the proposed method of management are presented.

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The Effects of Smoking on the Respiratory System in Normal Individuals. Kelly T. Me Kee, M. D. (Charleston) South. Med. J. 51: 1110, Sept. 1958.

A brief review of some of the observations on the local effects of the inhalation of tobacco smoke upon the respiratory system of normal individuals has been presented, along with a report of observations on the effects of tobacco smoking upon ventilation in a large group of normal individuals. While it appears unquestioned that smoking produces irritation of the larynx and adjacent areas, these studies do not demonstrate that ventilation is impaired in young healthy smokers.

Vesprin In The Treatment of Mental Disease. W. G. Morehouse, M. D. and J. E. Freed, M. D. (Columbia) Monogr. on Ther. 3:32, May 1958.

A total of 165 female, white patients under treatment with Vesprin (Triflupromazine) has been observed for periods varying from several weeks to several months since March, 1957. Of the 165 patients, 93 came from the admission ward of the hospital and were treated for short periods of time (up to several weeks); 72 came from the chronic disturbed wards of the hospital and were given Vesprin for at least several months. Slightly over two-thirds of both the new and chronic patients were considered to be improved while receiving the drug. It appears to be effective in reducing emotional disturbances in chronic psychiatric patients, making them more receptive to psychotherapy and other similar forms of treatment. Vesprin is unusually free from serious side effects. No blood dyscrasias, hepatitis, cerebral accidents or other serious side reactions were observed in this series.

*SODIUM CONTENT OF MUNICIPAL WATER SUPPLIES OF TOWNS AND CITIES OF SOUTH CAROLINA

KATHERINE R. BAILEY, B.S. M.P.H.

With the increased number of sodium restricted diets being prescribed for patients with cardiovascular-renal diseases, cirrhosis of the liver and other conditions in which there is increased sodium retention, the sodium content of municipal water supplies of the towns and cities of South Carolina is of especial importance.

Although the sodium content of the water supplies of most towns and cities of South Carolina is a negligible factor in the total daily intake of sodium, the waters of a few towns contain a sufficiently high sodium content that a total daily consumption of from two to two and a half liters would greatly alter the beneficial results of a sodium restricted diet. In such instances it may be desirable to use distilled water or that from a town having a low sodium content.

The cities and towns have been divided into the two following groups:

- (1) Cities and towns whose municipal water supplies range from 20 to 50 milligrams of sodium per liter, and
- (2) Those municipal water supplies that contain more than 50 milligrams sodium per liter.

Municipal waters of towns of less than 1000 population were not analyzed.

Towns whose municipal waters contained less than 20 milligrams of sodium per liter, an amount considered to be a negligible factor of the total daily intake, have been omitted.

The liter, which is 33.8 fluid ounces, or approximately four ordinary drinking glasses, was considered the best unit of measure for reporting.

1. Towns whose municipal waters contain 20 but not more than 50 milligrams sodium per liter.¹

<i>Town</i>	<i>Mg.Na/l</i>
Batesburg	20.0
Bennettsville	28.0
Central	20.0
Cheraw	29.0
Chester	25.0
Chesterfield	30.0
Dillon	20.0
Estill ²	54.0
Fairfax	25.0
Florence	31.0
Fort Mill	28.0
Holly Hill ³	25.0
Lancaster	44.0
Latta	26.0
Lexington	28.0
Manning	38.0
Marion	44.0
Mullins	50.0
St. George	39.0
St. Stephens	57.0
Summerville	47.0
Whitmire	30.0
Williamston	24.0
Winnsboro	29.0

2. Towns with more than 50 milligrams sodium per liter.

<i>Town</i>	<i>Mg.Na/l</i>
Andrews	158
Bamberg	52
Conway	264
Georgetown ⁴	246
Hampton	55
Kingstree	89
Moncks Corner ⁵	76
Myrtle Beach ⁶	300
St. Stephens	57
Summerton	54
Varnville	55
Walterboro	90

NOTES

1. In listing the sodium content of waters of towns and cities in which the analyses made on individual wells indicated a small variation the greater figure has been used. For towns whose waters have a wide range of sodium content the maximum sodium content is listed with the range given in the footnotes. Many towns pump water directly from the wells into the water mains and any excess that is not used is pumped into the storage tanks. The sodium content of the water in the mains of those towns in which there is a wide range of sodium may be much higher at some times than at others.

Chief, Dietetic Unit, VA Regional Office, Columbia, South Carolina.

2. The sodium content of the four wells at Estill varies as follows: 54, 54, 33, 7.3 mg. Na/l.
3. Of the two wells at Holly Hill the maximum content is 25, minimum content 7.7 mg. Na/l.
4. The sodium content of the five wells at Georgetown range between 246 maximum and 205 minimum.
5. Of the four wells at Moncks Corner the sodium content varies as follows: 18, 22, 44, and 76 mg. Na/l, respectively. However, the flow of the fourth well with the higher content of sodium has a flow in gallons per minute equal to the combined flow of the three other wells.
6. The sodium content of the nine wells at Myrtle Beach ranges from 62 to 388 mg. Na/l. Two wells yield water with a content of 62 and 117 mg. Na/l,

and the remaining seven wells range from 279 to 384 mg. Na/l. The mean sodium content may be presumed to be in excess of 300 mg. Na/l. Since water is pumped directly into the mains the sodium content may at times run as high as 388 mg. Na/l.

Analyses of the municipal water supplies of towns and cities of South Carolina were made by the district chemist of the U. S. Department of the Interior, Geological Survey in cooperation with the South Carolina Industrial Board. The complete tabulation has recently been finished and made available by Mr. Ralph Horton, District Agent, S. C. Industrial Development for this extraction.

Especial credit and appreciation are due Mr. G. A. Billingsley, District Chemist, who made valuable suggestions which have been incorporated in this report.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Digitalis Effect

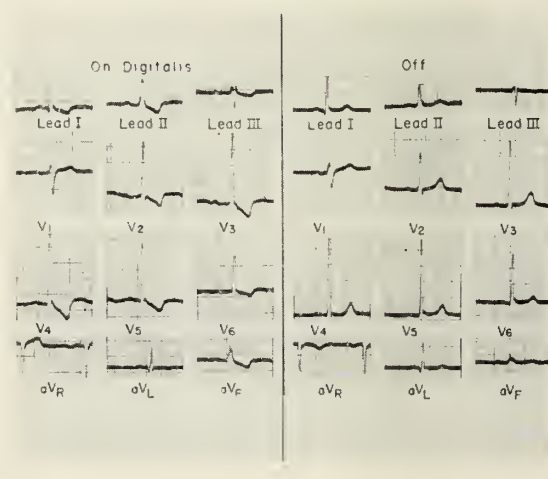
DALE GROOM, M. D.
Department of Medicine

Case Record—When under stress, a middle aged business executive experienced various functional symptoms, including what he described as “a shortness of breath.” Digitalis was one of several drugs he had collected in recent months, and this he had continued to take in daily maintenance dosage without any signs of toxicity. Apparently on a subsequent examination by another physician an electrocardiogram had been made and reported as abnormal. Thereafter the patient had restricted his physical activities in the belief that his heart was impaired.

Cardiac evaluation revealed no abnormalities other than those in the electrocardiogram pictured on the left. Most of the patient's symptoms could be reproduced by voluntary hyperventilation.

The tracing on the right was recorded several months after digitalis had been discontinued. Again at this examination, the patient's exercise tolerance was excellent and there was no evidence of heart disease.

Electrocardiogram—During digitalis administration the P-R interval is prolonged to 0.22 sec. (first degree A-V block) and the Q-T interval measures approximately 0.06 sec. shorter than the normal value of 0.36 sec. seen in the tracing on the right. That this difference in Q-T intervals is not due to a change in heart rate is evident from measurement of the R-R intervals in lead aVr (0.84 sec. = rate of 71 per minute) which are about the same in both tracings.



A prominent feature of the first electrocardiogram is the almost straight oblique downstroke of the S-T segments in most leads. They appear to “sag” into inverted and asymmetrical T waves. Small rounded deflections following the T, observed in V₃, V₄ and V₅ but absent after digitalis has been withdrawn, probably represent U waves.

The QRS complexes are unaltered by digitalis. Notable is the degree of counterclockwise rotation which they reveal, an incidental finding related to body build. As viewed from below, the heart is rotated counterclockwise on its long axis, shifting the transition zone to between the V₁ and V₂ positions and causing typical left ventricular complexes to appear as far to the right as V₂. Thus the deflections in V₂ and V₃ resemble those ordinarily encountered in V₅ and V₆. To the left of V₄ the R waves diminish in amplitude as the electrode is moved further from the area of maximum ventricular potentials.

Discussion—Digitalis in therapeutic dosage usually produces changes in the electrocardiogram which are quite characteristic and are commonly referred to as "digitalis effect." They are conspicuous in a comparison of these tracings recorded from a normal heart.

Electrically, digitalis affects predominantly repolarization and atrioventricular conduction, with little or no alteration of depolarization potentials. The repolarization changes are displayed best in leads recorded over the left ventricle— V_5 and V_6 in most instances, but in this case V_3 and V_4 due to the counterclockwise rotation of the heart. Most distinctive is the oblique downstroke of the S-T segments which may begin at or below the baseline, followed by the shorter upstroke of the T wave. Typically the slanting segments are either straight or show an upward concavity (as contrasted to those of coronary disease in which an upward convexity is the rule). Whether polarity of the T waves is reversed or not, they are "dragged down" by the S-T segments so that they generally appear either diphasic or inverted. Reciprocal changes with upright T waves and sometimes elevation of S-T segments are common in leads V_1 and aVr from the right side of the heart. The result is a configuration which is often recognizable as digitalis effect when viewed at a distance. In addition the Q-T interval is shortened by digitalis, U waves may become more prominent, and conduction of excitation through the atrioventricular node may be delayed giving a prolongation of the P-R interval.

Some or all of these changes usually develop in the electrocardiogram within a few hours after digitalization and persist for as long as two or three weeks after the drug has been discontinued. Although they provide a qualitative indication of the presence of digitalis they are not a reliable measure of either the degree of digitalization or of the therapeutic results.

The selective effect of digitalis on repolarization is of interest. Normally, repolarization proceeds from the epicardial surface inward through the ventricular wall—opposite to the direction of depolarization. Its polarity is also opposite, so that normal T waves are deflected in the same direction as the major QRS deflection in most leads. If, however, repolarization begins in the endocardial layers the T wave in, for example, V_6 , will be inverted. Or it may begin before depolarization is completed, in which case the S-T segment would be depressed, beginning below the baseline. Such S-T and T wave abnormalities are not secondary to a change in the course of depolarization as occurs in bundle branch block, but to a change in what has been called the "ventricular gradient", and may result from a variety of physical, chemical or metabolic changes in the myocardium. It seems likely that digitalis alters not only the rate but also the course of repolarization in some way, possibly in part through its influence on intracellular potassium. The accentuation of U waves which often occurs in digitalis effect has been ascribed to an action of the drug in driving potassium out of the cell.

Toxic doses of digitalis produce other abnormalities, mainly arrhythmias. These have already been discussed and include both atrial and ventricular ectopic rhythms (tachycardias, flutter, fibrillation), high degree atrioventricular blocks, sinus bradycardia, and particularly a bigeminal rhythm consisting of ventricular ectopic beats coupled with normally conducted beats, which is a classical electrocardiographic sign of digitalis intoxication.

Not always, of course, are the electrocardiographic manifestations of digitalis effect as typical nor as pronounced as in this patient's tracing, and commonly they are superimposed on the abnormalities of organic heart disease. Nor can one always differentiate with certainty the repolarization changes of digitalis from, e.g., those of "left ventricular strain." Obviously it is advisable to know whether or not a patient has recently received digitalis when interpreting his ECG (especially when evaluating abnormalities of the S-T segment, T waves, and the P-R interval) and, conversely, to examine a tracing for indications of the drug before administering digitalizing doses. Some patients know surprisingly little of the identity of their medications. On the other hand, cases are on record of deliberate use of digitalis to obtain a diagnosis of heart disease for purposes of compensation or evasion of military service.

This case illustrates a real pitfall in medicine, that of construing results of treatment as evidence of disease. The recognition of digitalis effect is of the utmost importance in the interpretation of electrocardiograms.

Note. This series of discussions of the electrocardiogram, having run now for three years in this *Journal*, will appear shortly in book form as *Clinics in Electrocardiography* (Charles C. Thomas, Publisher)

NEUROLOGICAL CONFERENCE

Acoustic Neuroma

Edited by

O. RHETT TALBERT, M. D.

DR. TALBERT: The case for presentation this morning is a fairly classical example of posterior fossa tumor, the most common such tumor encountered in adults. It is presented chiefly to illustrate the difficulties encountered in diagnosing this lesion early and the difficult problem involved in management of these cases when they are not diagnosed early.

Mrs. T. is a 62-year-old housewife admitted to the Medical College Hospital on January 6, 1958. The present major complaints are "I can hardly see. The left side of my face and tongue have no feeling in them". Her symptoms first began in 1950 with the onset of deafness in the left ear. She went to "two ear specialists" who told her the nerve to the ear was dead and that there was no satisfactory treatment for the condition. At times she would notice a ringing in

the left ear and a sound which she describes as "sh-h-h-h like the ocean". She remained otherwise asymptomatic until the summer of 1951 when she became "nervous" and irritable and noticed occasional transient disturbance of equilibrium. She was found to have an elevated blood pressure. She has been taking "blood pressure pills" off and on ever since then. The deafness, tinnitus, intermittent dizziness and disturbance of equilibrium continued at a more or less stable pace. There was no further definite change until August of 1956 when she developed a numbness of the left side of the face and tongue, the latter feeling "like I had scalded it with hot coffee". This became progressively more noticeable to the point that six months ago she became unable to taste anything on the left side of her tongue and had no feeling whatsoever over the left side of her face. Although the deafness in the left ear continued, she believes that either the tinnitus disappeared or she became so accustomed to it that it was not noticeable. About 3 months ago she developed a feeling of fullness in her head and some awareness of clouding in her thinking. For about the past year she has become gradually aware of visual difficulty. When she fixed her gaze on people she could not recognize them at first but after holding her gaze on them their faces would become distinct. Sometimes she would have "spots in front of my eyes like when you look at the sun then look away". This difficulty with vision necessitated that she stop driving an automobile. It is worthy of note that throughout the some seven years of her symptoms she was constantly under the care of a physician, in fact several physicians. In the fall of 1956 she tells us that she had some roentgenograms made but no change in her treatment was advised. We have no record of these films nor what, if any, diagnosis was made from them. She was fitted with glasses when her visual difficulty began, but with no benefit. For the past 3 months she has been progressively disabled by a worsening of dizziness, unsteadiness of gait, nervousness, light-headedness, and increasing impairment of vision. She has stopped walking almost completely except with someone supporting her. She denies any headache even up to the present time.

On examination you see that she appears well nourished and healthy. She is alert, quite apprehensive, but oriented as to time, place and person, and quite cooperative. She gives a good account of both remote and recent events, and in fact, gives no evidence of impaired mental faculties. Her speech is normal except for a faint, occasional tremor in her voice which we might well attribute to her apprehensive state. Sitting here in the chair she seems to have good use of herself. Now when we ask her to stand and walk for us you see that the fear of falling which has plagued her for the past several months is quite justifiable. She stands with her feet apart, quite uncertain of herself. As she walks she reaches constantly for support and is really quite

frantic in her fear that she will fall before we can catch her. There is about equally good use of the limbs on the two sides with no evidence of focal motor weakness. In fact, the impression is gained that she is not so much weak as unwilling to depend on her equilibrium to keep her in the upright position.

The general physical examination reveals nothing remarkable. Her blood pressure since hospitalization has ranged from 132/80 to 166/86.

On neurological examination, first of all, she has bilateral papilledema with scattered hemorrhages around the right disc. (It is worthy of note that her referring physician, under whose care she came only a month ago, described to me on the telephone the papilledema with essentially the picture of the fundus as just described. He examined her fundi when she first visited him a month ago and is quite certain that the discs were perfectly normal at that time. Therefore we have good evidence that the papilledema is of very recent development in spite of her history of visual difficulty dating back a year or so.) When she looks straight ahead her eyes are well aligned and quiet, and her pupils equal. On following the moving finger as she looks to the left of midline she develops a coarse horizontal nystagmus with the slow component toward the midline. Now if she follows the finger to the right she again develops a finer but persistent nystagmus with the slow component toward the midline. On following the finger upward or downward there is no vertical nystagmus. The pupils react briskly to light both directly and consensually. When you first look at her face it seems quite symmetrical with normal expressional movements but if you notice closely you see a slightly deeper nasolabial fold on the left than the right and if you watch her face you will see occasional, faint twitches of the facial musculature on the left, particularly around the upper lip and in the left lower eyelid. She closes the eyelids tightly with good power and about equally on the two sides and as she does so the grimacing movements of the face are about equal bilaterally. Again, though, when she increases her facial tone in this manner the fasciculations of the left side of the face become a little more pronounced. In retracting her lips and in attempting to whistle and on smiling the face is symmetrical. The external auditory canals are clear and the drums normal.

She cannot hear the tuning fork in the left ear by air conduction and there is marked diminution of bone conduction as compared to the opposite side. On the Weber test she lateralizes the sound consistently to the right ear. We have audiograms on her which show complete absence of bone and air conduction on the left. Caloric test of labyrinthine function showed nystagmus of 1-1/5 minutes on the left and 2-3/4 minutes on the right, indicating diminished function of the left. In other words, both auditory and vestibular components of eighth nerve function are

impaired on the left. The tongue and palate movements are normal but the gag reflex is absent on the left side. There is a diminution of pain sensation over the entire left side of her face, tongue and oral mucous membrane. The left corneal reflex is absent. Although she complains of a subjective feeling of numbness over the left side of the face, it is difficult to demonstrate any consistent lack of light touch over that side with the cotton. As she clenches the jaws the masseter and temporalis muscles are of about equal bulk and strength of contraction in the two sides and her jaw does not deviate on opening her mouth against force, indicating that the motor component of the fifth nerve is intact. Testing for taste sensation was done on the ward this morning and Dr. Manos reports diminution of taste over the left side of the tongue as well as the numbness to pinprick that we have just demonstrated. This indicates impairment of both the fifth nerve sensory component and the seventh nerve taste component.

When we have her extend her arms in front of her with the fingers spread apart there is a slight instability of the position of the upper limbs. She performs the finger-to-nose test in a clumsy fashion bilaterally and you see a fine rhythmic tremor of each extremity as she moves her finger from my finger to her nose and back. No doubt, this instability of movement is at least partly the explanation for what she has assumed to be "nervousness". There is no distinct difference in the ataxia between the two upper limbs. Again we note that there is good muscle development in both the proximal and distal groups of the upper extremities. Her grip is quite good bilaterally. On passive movement of the limbs I can detect no alteration of muscle tone.

The tendon reflexes are present and equal throughout except for the radial-periosteal reflex which is slightly brisker on the left than on the right. The plantar reflexes are both flexor although that on the left is not as distinctly so as the right. Pain, light touch, temperature, position, tactile localization and stereognostic sensibility are all intact throughout.

In brief summary then, the case is that of a middle-aged woman with the insidious onset of hearing loss and tinnitus in the left ear 7 years ago. This has gradually progressed and as the years have gone by she has developed ataxia and dizziness which she attributed to high blood pressure. More recently she has developed a feeling of numbness over the left side of the face and tongue and a feeling of fullness in her head. A progressive impairment of vision bilaterally has developed within the past year and her total array of symptoms has progressed to the point that she has been unable to get around at all without assistance for the past several months. Examination reveals evidence of increased intracranial pressure, impairment of function of the fifth, seventh, eighth and ninth cranial nerves on the left side, and impairment of cerebellar function bilaterally. There is

no indication of involvement of the motor or sensory tracts passing through the brain stem and the cranial nerves on the right are conspicuously spared.

We are immediately led by the multiple cranial nerve and cerebellar involvement to consideration of a lesion in the posterior fossa of the cranial vault. But let us consider the symptoms in the light of their development. The symptoms of tinnitus, hearing loss and dizziness are the classical ones of Meniere's syndrome at first glance. However that syndrome is a disorder of the end organs of hearing and equilibrium (i.e. the vestibular canals and cochlea in the inner ear) and would not account for the involvement of the other cranial nerves and cerebellar function that we have demonstrated. Therefore we could immediately dispense with this diagnosis even if she did not have papilledema. The dizziness and ataxia of which she has complained for seven years are among the most common symptoms we encounter in clinical practice, particularly in women. We are prone too often to pass it off as "psychogenic" or due to hypertension as seems to have been the case here. However the presence of deafness on one side should immediately make one think of a more localized lesion. The slowly progressive development of the symptoms would be quite incompatible with a vascular lesion, even though she was known to be hypertensive. There are a number of diagnostic possibilities that could have been justifiably entertained through the years but the point to be made is that the combination of symptoms and signs implicating the fifth, seventh and eighth cranial nerves on one side and the disturbance of equilibrium, vague although it may have been, should always make one suspect and take steps to rule out a lesion in the posterior fossa. Since one of the most common posterior fossa lesions developing in this slowly progressive manner is an acoustic neuroma, roentgenograms of the skull, including a view to visualize the petrous bones and internal auditory meati is perhaps the first ancillary study that should be obtained. We have roentgenograms of the skull and I should like to ask Dr. Hodges to present those to us.

DR. HODGES: We have the usual series of skull films here including a Towne projection. On the Towne view (Fig. 1) you can see that on the left the apex of the petrous bone is destroyed and the internal auditory canal is irregularly eroded in its medial aspect. In comparison, you will see that the right petrous apex is quite well outlined and the internal auditory meatus is of normal size. The other views show nothing of consequence except that on the basilar view we see on the right a normal petrous bone but on the left there is an irregular area of bone destruction. On the lateral view we do find the posterior clinoid processes thin, indicating increased intracranial pressure. The sella turcica is normal in size.

DR. TALBERT: Thank you. This is a situation in which the diagnosis is unfortunately easy in the stage



at which we see it. Had we examined the patient 4 or 5 years ago it would have been considerably more difficult. On the other hand, if one is aware of the possibility, this tumor can be diagnosed long before it has reached the stage of the present case. An acoustic neuroma (also designated as acoustic neurofibroma, Schwannoma, perineural fibroblastoma, and cerebellopontine angle tumor) is the most frequent posterior fossa tumor in adults. It is usually unilateral and, as the term cerebellopontine angle tumor implies is nestled in the angle between the side of the pons and the ventral aspect of the cerebellar hemisphere. It is an intrinsic tumor of the eighth nerve which emerges from the brain stem in the angle. It is usually unilateral, although on rare occasions a bilateral tumor is found. This is particularly true in Von Recklinghausen's neurofibromatosis in which there may be similar tumors of multiple cranial and peripheral nerves over the body. The single neurofibroma may involve other cranial or peripheral nerves but for some unknown reason it involves the eighth nerve much more frequently than the others. It characteristically arises on the nerve at or near the point where it leaves the floor of the skull by way of the internal auditory meatus. Since it grows into the internal auditory meatus, expanding that canal, it is likely to produce distortion and erosion of the canal early in its course. Therefore it can often be diagnosed quite early by a careful examination and comparison of the internal auditory meati on the so-called Towne view of the skull roentgenogram. The tumor histologically is benign, yet because of its tendency to invade the internal auditory canal, it is extremely difficult to remove surgically even in its early stages.

The usual clinical course of this tumor is classically exemplified in this patient. The very first symptom is usually unilateral hearing loss and tinnitus. Either before or after the onset of deafness there is usually some disturbance of equilibrium although this is often nothing more than a minimal subjective feeling of unsteadiness. The course is usually measured in years since it is a slowly growing tumor. Once it has grown to sufficient size to involve other structures than the eighth nerve the most common symptom to be added is that of involvement of the fifth nerve. The earliest manifestation of involvement of this nerve is a diminution or loss of the corneal reflex on the same side. Therefore one should always check the corneal reflexes in patients presenting with this array of symptoms. As the fifth nerve becomes more completely involved loss of sensation over the side of the face on the side of the tumor develops, as was the case here. Next most frequently involved is the seventh (facial) nerve on the same side. This may take the form of a minimal facial weakness or, as is the case here, symptoms of irritation in the form of unilateral fasciculations or facial spasm and contraction.

Since the tumor lies adjacent to the cerebellar peduncles, cerebellar signs in the form of ataxia and nystagmus are likely to develop fairly early in the course. Of course, the nystagmus and disturbance of equilibrium are probably due to both vestibular and cerebellar involvement, the former being a function of the eighth nerve. The cerebellar impairment usually remains dominant on the side of the tumor but may be bilateral from the beginning. Because the tumor is outside the brain stem, it must reach considerable size before it creates sufficient pressure to block the flow of spinal fluid through the aqueduct and fourth ventricle. Therefore signs of increased intracranial pressure such as papilledema, headaches and vomiting do not develop until the very late stages. This is in contrast to an intrinsic brain stem tumor where increased pressure may be an early sign. Another point of differentiation between this tumor and an intrinsic brain stem tumor is the unilateral involvement of multiple cranial nerves and the absence of involvement of the sensory and motor tracts passing through the brain stem, both of which occur much earlier in the intrinsic tumors. Acoustic neuroma can be differentiated from a primary cerebellar tumor by the early and marked eighth nerve involvement. We have already pointed out that the diagnosis can be made relatively early in the course by x-ray examination of the internal auditory meati. The other important and very helpful diagnostic method is examination of the spinal fluid. Almost invariably this particular tumor causes elevation of the spinal fluid protein.

I do not wish to imply that once the diagnosis is suspected the patient need be rushed into surgery. On the contrary, it is often wise to forego surgery even when one is fairly sure of the diagnosis, so long as the patient is tolerating the tumor without any notice-

able increase in signs. You have plenty of time because the course of the tumor is measured in years. On the other hand, it is technically a difficult tumor to remove and it is not wise to postpone surgery until it has so deeply invaded the internal auditory meatus and so compressed the brain stem structures that its removal involves unavoidable brain stem damage. Dr. Martin, would you please comment from the surgical standpoint on this case?

DR. LUTHER MARTIN: Well, I don't need to say a great deal about the surgical management but I hope you all have this picture clearly in mind because it is a very classic example. You will only occasionally see one this far advanced. Now, although this lady's problem is diagnosed I think her chances of having the tumor removed extremely slim. Once these tumors have reached what we call stage 4, surgical removal is practically hopeless. Dr. Talbert did not give you the development by stages in which we like to grade them from the surgical standpoint. We usually grade them from stage 1 through stage 4, stage 4 being that in which increased pressure develops. This means that the tumor is stuck to the side of the pons and obstructing the aqueduct and fourth ventricle. Of course, you can pull it away at surgery but this does

so much damage to the vital brain stem structures that the patient is not likely to be able to survive it. So I think the early diagnosis is so important if we are to get at them before this takes place and while they are relatively free from attachment to the brain stem.

In spite of the bad prognosis surgically here, I believe we should go ahead with an operation, because she has increased intracranial pressure that she cannot tolerate for long. There is a chance we may be able to relieve this, but the hope of doing anything more is very slim.

Addendum: Exploration of the posterior fossa was performed the following day by Dr. Luther Martin. A firm, yellow, encapsulated tumor "the size of a lime" was encountered in the region of the eighth cranial nerve on the right. Histologic examination revealed it to be a typical neuroma. Part of the tumor was removed and a Torkildsen procedure done. Immediate postoperative condition was good. Two days later the patient developed respiratory paralysis and peripheral circulatory collapse and died. Autopsy revealed massive necrosis and edema of the brain stem and both cerebellar hemispheres.

PHYSICAL FITNESS OF THE SCHOOL-AGE CHILD

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Fitness is a difficult word to define, especially when one attempts to relate it to the school age child. For purposes of discussion one must consider the total or entire child, and certainly one must include emotional, mental, and physical aspects. It would seem more desirable for the physician member of this panel to largely limit his remarks to the physical side of fitness since there are more capable discussants here to cover the other more nebulous aspects.

In order to discuss the physical attributes and health problems of the school age child one may best separate school children into pre-adolescent and adolescent groups or ages.

Growth

From the end of the first year to the sixth year growth is slow and tends to be relatively greater in linear growth. During these pre-school years there is an accompanying increase in physical activity and improved muscular and motor coordination and function, as well as rapid mental growth.

Physical growth of the school age child tends to increase steadily from approximately six years up to the adolescent years. Generally, growth is slow and progressive, and does not deviate from this pattern until onset of puberty, when there is a rapid increase in the rate of growth. From six to twelve years, there is an increasing slow growth in height and correspond-

ing but more rapid weight increase, girls' growth being more accelerated.

Diseases and Infections

The school age child is susceptible to various infectious diseases, particularly the so-called respiratory viral infections, which include all of the common contagious diseases of childhood. Epidemic outbreaks of influenza, streptococcal sore throat, viral herpanginal sore throats, as well as the common cold, are encountered among our overcrowded schools practically every year. While acute respiratory infections make up the major group of school age illnesses, only rarely do we encounter serious, chronic, or recurrent difficulties. At the present time there is world-wide anxiety among medical authorities concerning the spread of staphylococcal infections which are presently a problem chiefly of young infants, old and debilitated individuals, and hospitalized patients. Nevertheless, this infection can become a serious problem when it complicates the relatively minor illnesses of childhood.

Non-preventable contagious diseases, especially chicken-pox, mumps, German measles, scarlet fever, when promptly or adequately treated, and measles (which can be modified) seldom have severe complications in the previously healthy child.

Anemias of the school child are usually of moderate degree and generally a direct result of inadequate

iron in the diet. Such diets generally consist largely of excessive milk and carbohydrates, with little or no protein foods.

Acute or advanced illnesses or diseases are not difficult to detect. However, the important health problems of childhood are typically asymptomatic and vague in nature. For instance, sub-optimal growth, moderate anemias, nutritional deficiencies, visual disorders, hearing difficulty, childhood tuberculosis, and other less frequent disease states, are difficult to detect and often require special investigation and study.

Accidents

Another major problem affecting the health of the school age child not typically considered a disease is certainly of utmost concern. I am alluding to accidents, which are the leading cause of death in all children under 15 years of age. Preschool and younger school children are most frequently injured in the home, but are not immune to injury at school. It is estimated that there are 17,000 deaths yearly under 15 years of age in the United States from accidents alone. Approximately 2,000,000 children are incapacitated yearly for varying periods of time, and more than 50,000 are crippled permanently each year from accidents. The majority of the serious accidents are results of falls, burns, vehicle accidents, poisoning, and drowning. The suffering and expense is appalling! Incidentally, while speaking of accidents, I have been informed that our school busses are frequently overcrowded far beyond load capacity. Certainly all safety rules should be enforced in our school transportation when we consider the high price we must pay for serious accidents involving our school busses.

Dental Health

We should not forget dental caries as a very serious problem in our school age child. No doubt our highly civilized dietary advances, (or should I say dietary decline?) and advanced food salesmanship, has reached the point where we often neglect much needed nutritional and roughage factors which are consistent with good dental health. No doubt a large proportion of dental caries of the school age child (estimated 90%) is the direct result of the high carbohydrate, low roughage diet we encounter in the average American home, plus poor dental hygiene. Needless to say, cod liver oil and calcium are still valuable adjuncts in proper growth of bones and teeth. I believe that the school authorities would do a great service to their students if the school canteens were abolished, or required to stock only fruits, fruit juices, and milk rather than candies, cookies, chewing gum, etc.

Special Tests

Visual disturbances in the school age child are frequently familial, especially myopia and hyperopia, and can best be detected by proper eye examinations before the child reaches school age. Serious loss of vision may occur, however, after a child reaches school age and throughout the child's school career.

Hence, the need for repeated periodic vision screening tests should be evident. Certainly eye screening tests ideally should be done with the child's yearly physical examination, but testing every two to three years would be of major benefit.

Hearing tests should be available for all children who are subject to repeated ear infections or who have had frequent ear infections prior to school. Inattention, dislike of school, failures,—all may be the result of poor visual or auditory functions. Obviously a simple hearing test should be done on all children before starting school and at periodic intervals.

A routine pre-school tuberculin test should also be performed as part of the pre-school examination. All positive reactions would of course need special study and investigation. Such tests should be repeated at intervals as part of the child's routine health program.

Adolescent Years

Adolescent school years are characterized by a most rapid growth spurt with accompanying sexual maturation and often a corresponding emotional instability. Health problems of the adolescent parallel those of the earlier school years; however, nutritional deficiencies variously caused by faddish or poor dietary habits are more common at this age. Skin disorders, especially seborrheic scalp and face disorders, acne, and eczema, are problems of both sexes in adolescent years. These skin disorders are frequently the result of the combined factors of improper diet, poor skin care, with superimposed infection, as well as accompanying endocrine dysfunction of adolescence.

Because of the rapid growth in adolescence and often sub-optimal nutrition and rest, the adolescent child is more susceptible to tuberculous infections, or reinfection in previously unrecognized childhood type infections.

Emotional Development

The child's emotional development certainly is greatly influenced by his school environment. Needless to say, a mature, sympathetic, teacher exerts a wonderful influence on a youngster who has had a poor home background. However, a tremendous amount of harm can conversely occur in emotionally unbalanced children who have an immature or unsympathetic, haggling teacher.

Psychoneurotic parents tend to beget or develop psychoneurotic children. A child must have several basic needs supplied in the home or school, preferably in both places, if he or she is to grow and mature emotionally as well as physically. One may simplify these needs as: love, or a feeling of being wanted and needed; individual respect or self-esteem, self confidence; and the need of discipline is also a basic essential for good emotional growth. If these oversimplified factors are available for the growing child at home, then we will find a stable, secure child in most instances. The teacher may serve as a most valuable parent substitute to the emotionally hungry, insecure, child.

Immunizations

Finally I should like to comment on immunization. The enlightened parents will have had their children immunized prior to entry into school. The State of South Carolina requires smallpox vaccination only. How many parents realize that periodic recall or booster doses are indicated for diseases such as diphtheria through ten years of age; tetanus throughout the school years and preferably periodically throughout the individual's life, and smallpox every five years. It is deemed advisable to discontinue whooping cough immunization after the child enters school. Typhoid series are generally indicated in semi-rural or rural areas periodically. Finally, poliomyelitis immunizations at present are considered adequate following three doses of Salk vaccine. A fourth injection in the face of a developing epidemic or local outbreak would seem advisable.

The lack of physical fitness of the school age child should be a matter of utmost concern to every parent,

every educator or teacher in our country. With little argument, we can find ample statistics and evidence of the American adult and especially the child's physical softness. Will Rogers many years ago stated that "we are fast becoming a generation of thumbs"—and he preceeded the era of the three car family and the true pushbutton age. As parents, are we helping our child's physical, mental, or emotional growth when we allow endless hours of television and comic reading? How many of our school age kids walk to school before they learn to drive or possess their own tin lizzy to make it unsafe for others to do what they should be doing? I firmly believe that each and every child should learn to swim in the early school years. If manual training or mechanical drawing is a major subject in our educational system, then a properly conducted physical education course should be a compulsory minor course from which each and every child could benefit. Those who refuse physical training should have the opportunity of blowing the tuba in the marching school band.

THE PHYSICIAN'S ROLE IN THE SOCIAL SECURITY DISABILITY PROGRAM

Released by

P. G. SHERER,

Director, Vocational Rehabilitation Department

Doctors, hospitals, institutions, and agencies who have contact with disabled people are frequently asked these days to fill out medical reports in connection with claims under the disability provisions of the social security law. Under these provisions, disabled workers 50 to 65 years of age, and the disabled dependent sons and daughters of retired or deceased workers, may receive monthly disability payments. Disabled workers under age 50 may have their social security records "frozen." This protects the future benefit rights of the disabled worker and his family.

To qualify under these disability provisions, a person must be unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration. A disabled worker must, in addition, have social security credits for work in at least 5 out of the 10 years before he became disabled, including a year and a half out of the 3 years before his disability began. A disabled child must be both unmarried and dependent, and must have become disabled before his or her 18th birthday.

Applications under the social security disability provisions are taken by the more than 570 social security district offices, located in communities all over the

nation. The social security district office gives the disabled applicant information about his rights, helps him to fill out his application, and to get the proofs and documents he may need to support that application. Under the law, the disabled person is responsible for furnishing, at his own expense, the evidence to show that he is "disabled" within the meaning of the social security law.

His social security district office gives him one or more copies of a medical report form on which this evidence can be supplied. He is asked to take or mail this form to his attending physician or to a hospital, institution, public or private agency where he has been treated for his disabling condition. This report form, designed as a guide for the reporting physician, lists the kind of medical facts essential for the determination of "disability." However, the reporting doctor is not required to use it; if he prefers, he may make his report in the form of a narrative summary or he may submit photocopies of the pertinent medical records. The completed reports are to be returned by mail to the social security district office (or to a state agency, if indicated).

By providing a full and objective clinical picture of his patient, the reporting doctor fulfills his responsibility to his patient and, incidentally, expedites the decision. To be of maximum use for the evaluation of a

patient's capacity for work, the report should include a history of the impairment, the symptomatology, clinical findings and diagnosis. Obviously, the reporting physician has an important role in the operation of the social security disability provisions. He is not, however, asked to decide the issue of "disability". The determination as to whether a patient is "disabled" must be made within the scope of the social security law; often it is based on evidence from more than one medical source. Also the determination must take into account factors which are not purely medical—factors such as education, training and work experience.

After the applicant has filed his claim under the disability provisions, and furnished the supporting evidence, his case is forwarded by his social security district office to an agency of his state. Under agreements between the individual states and the Federal Government, these state agencies make the disability determinations for their own residents.

In the State of South Carolina, the agreement with the Federal Government provides for the State Vocational Rehabilitation Department to make these disability determinations, except that determinations due to impairment of vision are made by the Division of the Blind of the State Department of Public Welfare.

The evaluation of disability is made by a "review team" in the state agency. There are at least two professional people on each team. One of the two is a doctor of medicine (often a practicing physician who serves with the state agency on a part-time basis); the other is trained in evaluating the personal and vocational aspects of disability. The team must decide whether the applicant is sufficiently disabled to prevent him from engaging in any substantial gainful activity within the foreseeable future.

In many cases it is necessary to write back to the reporting physician because the medical report does not contain enough clinical facts. As a rule, the kinds of medical facts that the attending physician needs in making his diagnosis and in treating his patient are the same as those required to evaluate the severity of impairments in disability programs. However, certain medical facts are more highly significant in disability evaluation than to medical management of the case. To evaluate the effect of the impairment on the individual's ability to work requires the kind of medical evidence that confirms the diagnosis and measures remaining functional capacities of mind and body. By furnishing complete and objective evidence, the reporting physician makes it unnecessary for the reviewing physician to "write back" for additional clinical or laboratory data.

Where the medical evidence initially submitted indicates a reasonable likelihood that the applicant is disabled, but more precise clinical or laboratory findings are needed to arrive at a sound decision, or to resolve conflicts in the evidence, a consultative examination (usually at the specialist level) may be ordered to obtain additional information. Selection

of consulting physicians and payment of fees are governed by state practices.

Some doctors feel that they should be reimbursed by the Government for the cost of preparing the medical reports on their patients, and it is, of course, quite within their prerogative to charge the patient a fee for that service. However, under the law, the Social Security Administration cannot pay that fee; that is the individual's responsibility.

Other doctors are perturbed when asked to complete medical reports for individuals whom they may not have seen for years. In these cases, however, the physician is not expected to describe the present condition of the patient, but his medical condition as of the time he made his last examination. Although the social security disability provisions were made applicable to persons whose disabilities may have begun as far back as 1941, all those with long-standing disabilities must apply before July 1, 1958. After June 1958, therefore, this problem should be much relieved.

Evaluation of Disability

The central purpose of disability evaluation is to determine remaining mental and physical capacities. To determine: (1) what the claimant has left, and (2) what he can do with what he has left.

A realistic evaluation of disability must be based on clinical and laboratory tests of the individual's ability to meet the metabolic demands of activity, to reason, to perceive, and to perform certain basic activities such as sitting, standing, bending and walking. When incapacity results from severe impairment of one or more such functions, it is essential to establish not only the fact that functional impairment exists, but also its extent.

A brief discussion of disability from heart disease may serve to illustrate the kind of evidence needed to measure the patient's remaining functional capacity, after appropriate therapy. Most frequently, impairments of the circulatory system produce loss of bodily function by reduction of cardiac reserve, or interference with peripheral vascular circulation. As a result the circulatory apparatus cannot meet effectively the metabolic demands placed upon it. The diagnosis of the condition usually indicates whether the impairment is caused by valvular disease, myocardial damage or vascular pathology.

Cardiac size by x-ray examination or physical and electrocardiographic findings furnish objective proof of cardiac pathology. The amount of dyspnea or angina described in terms of the number of steps that can be mounted or distance in feet or blocks that the patient can walk is highly significant to evaluation of the degree of loss of function. The presence or absence of cardiac edema and response to therapy are also indicative of the severity of cardiovascular impairments. The status of the pulse in the peripheral vessels may provide gross clinical evidence of impaired circulation of the extremities.

Impairments of the cardiovascular system may manifest themselves with dramatic suddenness, e.g.,

myocardial infarction, obstruction of vessels in peripheral or central nervous system circulation, lungs, and other visceral organs. The initial clinical manifestations are severe and the prognosis dubious. With survival from the acute stage, and appropriate therapy, substantial improvement can be expected over a period of time. A realistic evaluation of remaining function should be made after the convalescent period. Hence, the clinical and laboratory findings after maximum improvement from treatment are particularly valuable in making a determination of remaining cardiac, brain or other function. (Note that a "waiting period", is prescribed by law, i.e., the first monthly disability insurance benefit cannot be paid until the seventh month after the onset of the disability.) A description of the acute attack helps confirm the diagnosis and should therefore be included in the report.

Loss of function is evaluated on the basis of clinical and laboratory findings after maximum benefit from treatment. Clinical information concerning the nature of the loss and response to treatment furnishes information on stability of functional capacity, i.e., a history of periodic decompensated heart disease, in spite of treatment, would indicate a comparatively severe condition.

More complicated tests of vascular function may be required in certain cases, e.g., arteriography. The re-

porting physician should not be concerned because he may not have equipment to perform these tests. A carefully performed exercise tolerance test (if not medically contraindicated) will almost always provide the clinical evidence needed to evaluate the degree of remaining function.

Conclusion

In developing evaluation guides for the use of the state agency and its own technical and professional personnel, the Social Security Administration has had the continuing cooperation of a Medical Advisory Committee appointed by Commissioner Schottland, in February 1955. The Committee is composed of recognized specialists associated with medical and allied professions in various fields outside Government, such as general practice, research, medical education, industry and labor.

The American Medical Association has cooperated with the Social Security Administration by informing its members about the medical aspects of the disability program, especially the preparation of medical reports. On June 1, 1957, *The Journal of the American Medical Association* carried a comprehensive report on the administration and organization of the disability provisions. Regulations on the meaning of disability appeared in the September 28, 1957, issue.



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PRESIDENT'S PAGE

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill, or which tend to cause a deterioration of the quality of medical care.

Contract practice *per se* is not unethical. However, under certain conditions it becomes unethical. These conditions are: inadequate compensable fee schedule making it impossible to render competent care; underbidding by physicians in order to secure a contract when the community is denied a reasonable degree of free choice of physicians; and, last but not least, the solicitation of patients either directly or indirectly. On the other hand it is quite ethical for a doctor to enter into a contract with firms and corporations to properly care for accidents occurring in the transaction of their businesses, to practice preventive medicine for the betterment of the health condition of the employees, and for the purpose of practicing general medicine among the employees of industrial plants located in isolated areas widely distant from towns and places where physicians would naturally locate, provided he is paid a fair living wage for his services, and provided his medical skill and judgment are not hampered by restrictions.

Management in industry recognizes the fact that it is just as important for it to have a medical department as it is to establish employment offices. Pre-employment examinations, preventive health and accident measures, and the proper handling of accidental injuries are a must if industrial organizations expect to prosper in this highly competitive age. As physicians, we should do all in our power to care for their needs, much the same as we care for the individual patient, when given the proper opportunity to help and participate in these necessities.

The age-old professional ideal that medical service must be rendered to all, whether able to pay or not, is one of the strongest holds we have on public approval and support. That ideal is basic in our ethics. The abandonment of this ideal and the adoption of the principle of service only when paid for would be the biggest step towards socialization of our art that the medical profession has ever taken. If such service is not rendered, the deaf ears of our legislators and a majority of our population will be turned to our arguments about better service to the people and freedom of choice of doctors.

R. L. Crawford, President

Editorials

THE AMA NEWS

A new publication by the American Medical Association which represents an effort to keep information current and fresh for the many members of the Association appeared in September and is to continue as a regular service of the A.M.A. This tabloid-type paper is to carry a variety of material, news of people, new developments, some advertising, cartoons, editorials, etc., etc. This material is presented in a reasonably popular form and covers a wide range of interests.

The *News* has had several predecessors which have aimed at somewhat the same kind of approach, and they have been received kindly, some of them even enthusiastically, by medical readers. Their standards have been quite high and their material is in readable form. It seems sure that the A.M.A. *News* will be a very satisfactory addition to the already available medical newspapers, and with the high standard of production always visible in a journal of the A.M.A., it is to be expected that it will continue to be a very desirable production.

THE NATIONAL FOUNDATION

Having labored valiantly over the years in the field of poliomyelitis, and having achieved through the success of the Salk vaccine a large measure of success in the control of the disease, The National Foundation for Infantile Paralysis has taken stock of itself and decided that since it has to a large extent attained its original objective and since demands on it from poliomyelitis alone should be less and less, it must turn to new fields of endeavor. It does not now abandon anything except that part which poliomyelitis played in its name, and intends to continue with its activities against that disease. This announcement, in the rather characteristic dramatic approach of the Foundation, was made on a closed television circuit to specially invited audiences over the country, and was amplified in a soul-searching

booklet distributed to a rather large medical audience.

Now that polio is declining, or at least paralytic polio is declining, and the value of the vaccine has been established, even though it is poorly utilized, the Foundation, having built a huge structure of education, research and fund raising must find new fields, new appeals and new subjects. On the basis of a decision by many wise people, the Foundation plans to attack as its basic objective the great problem of arthritis, and to add as a new field the rather small one covering spina bifida, hydrocephalus, and the encephalocoele group, all composing a relatively minor group as far as services are concerned, but a group with a tremendous potential of emotional appeal to the public for its contributions of funds.

The Foundation has a most effective organization for procuring funds. Actually in the past, the take has at times been so big that the Foundation has appeared to be rather hard put to find projects remotely bearing on polio on which to spend its money. There can be no complaint about successful fund-raising campaigns, unless one might question whether the donors of the dimes would really be content with some of the ways in which their funds were used.

It is to be hoped that the top level policy makers will be given the light to follow the main courses and not give too much stage dressing or fritter away money given with specific objectives in the mind of the man in the street when he deposits his money in the little box. In giving, as in taking, the dimes should march, not sprint.

There has been some unfortunate conflict with the Arthritis and Rheumatism Foundation, a well established organization which has had ten years of activity and collected as much as three million dollars in 1957-58 through its 53 Chapters scattered over the country. There was an effort to bring about a merger of activity and funds with this organization, but

the decision was reached that this Foundation would continue along its own way. One of the chief matters of contention appeared to be the fact that the policy of the National Foundation was derived from a central organization, while the Arthritis and Rheumatism Foundation allowed its Chapters a great deal of local autonomy. To the latter arrangement we would feel kindly inclined rather than to the "new-dealish" attitude of the National Foundation. It is hoped that an amicable solution can be reached in the differences between these two active bodies. It may be imagined that there may be some lack of cordiality of feeling since the National Foundation appears to have proposed that the ten year old Arthritis and Rheumatism Foundation give up its activities, disband, and leave the field to the giant of voluntary agencies.

The expected continuation of the National Foundation as a successful fund raiser is not unpleasant to contemplate. It will represent a voluntary effort of millions of people over the country to do something in the field of medical research and medical care which is not readily available from other sources. It is quite likely that additional projects may be included, and unimagined benefits may accrue to all of us.

THE FAMILY PHYSICIAN

Periodically the medical muezzin from his ivory minaret (or is it plastic?) calls aloud the decline of the family physician and the rise of the institutional practitioner. Periodically he asks the gifts of the public (by way of the many foundations) to bear him along in his research-practice, and cautions us to beware of the deficiencies of the doctor on the street.

If he is right, a survey* made three years ago, but probably still quite current in its implication, does not bear him out entirely. The report of this survey begins thus; "Despite the increasing importance of specialists, the family physician remains a key figure in modern medical practice. He is medical adviser and manager for the overwhelming majority of our population, and for many he remains the sole point of contact with the medical profession. As a result, he is the single physician

most likely to influence the public's conception of medical practice."

The survey, made by sampling over all the areas of the country, in both small and large communities, showed that most of the family physicians are relatively young men (in or below their forties), and that the younger physicians are generally concentrated in smaller communities. Nearly three fourths do general practice in the usual sense. They work 60 hours a week, and make (as a median figure) about \$15,000 a year before taxes.

The day of the house call has evidently not gone, as 13 out of 14 of these doctors made calls at patients homes, and 4 out of 5 made calls at night and on Sundays. Seven out of 8 were affiliated with one or more hospitals. The average physician saw 26 patients a day, mostly in his office.

The material gain of the practicing physician has been sometimes a point of envy for the institutional practitioner, who may be dazzled by the large incomes of such relatively rare medical financial genius as the neurological surgeon, for instance, may display. The figures of this survey may mollify his envy, if indeed he does not reckon the smaller demands on his time and effort.

The focal point of medical care has not shifted. Four out of five families employ a family physician, who is all too happy to have the expert in the institution to ease doctor and patient over the hard spots by his superior specialized knowledge.

*Progress in Health Services 8: June 1958.

NEWS

WASHINGTON NEWS

When the Congress that is elected in November goes to work next January 7 it will have before it a half dozen important health-medical issues that the last Congress took some interest in but didn't resolve. They include hospitalization under social security, tax-deferment on annuities, loans and mortgage guarantees for hospitals and nursing homes, aid to medical schools and amendment of Veterans Administration's hospitalization procedures.

The issue of hospitalization under social security—the Forand bill principle—will come into the spotlight shortly after the new session starts. Under instructions from the House Ways and Means Com-

mittee, the Department of Health, Education, and Welfare will complete a study on the problems of financing hospital care for the aged before next February 1. Some study of medical costs may also be included.

Decision to move ahead with a study of medical care costs for the aged was reached by the committee at the same time it excluded the Forand idea from the social security bill enacted during the summer. HEW was told to pay particular attention to the possibility of increasing OASI taxes, and with the money purchasing health insurance (nonprofit or commercial) to take effect upon retirement or disability. This would differ from the Forand plan in that health care would be financed through insurance, and not paid for directly by the Federal government.

The Keogh bill to allow doctors and other self-employed to defer income taxes on money put into retirement funds passed the House with very little opposition but encountered difficulty in the Senate. It was defeated there in the closing days, and under unusual circumstances. Policy committees of both parties decided to oppose the bill as too costly, and the vote came in the course of a complicated legislative maneuver that could not be used as a test of whether individual Senators favored or opposed the bill itself.

Keogh bill sponsors, however, are encouraged that 32 Senators resisted official party instructions and stayed with the pension plan. They are confident that next year under more favorable legislative circumstances the measure will clear the Senate.

An effort was made late in the session to authorize grants to medical schools for building and equipping teaching as well as research facilities. The bill extending the research grants program also would have allowed use of the grants for "multi-purpose" structures (teaching and research) if emphasis were on research. However, for fear this change would hold up the simple extension bill, it was dropped off before the bill reached the House floor. Sponsors of aid to medical education will be back next year and campaign on this issue alone.

Legislation for U. S. guarantee of nursing home mortgages, strongly supported by the American Medical Association, fell by the wayside in the House during the closing hours of the session, after having cleared the Senate with no trouble whatever. This also will be pushed next year, and may have a better chance of passage because of the growing emphasis on need for solving the problems of the aged.

Far too late for passage, Chairman Olin Teague's House Veterans Affairs Committee reported out a bill that would make a number of changes in VA hospitalization procedures, liberalizing some and tightening up on others. The bill also would require VA to open 5,000 beds over which Mr. Teague and VA Administrator Whittier have been squabbling for months, the latter maintaining that the beds aren't needed.

That issue still is unresolved, inasmuch as the bill didn't pass.

Congress did roll out a sizeable list of medical-health laws. It ordered the calling of a 1961 White House Conference on the Aging, gave food and Drug Administration authority to enforce its pre-testing standards on foods to which chemicals and other substances have been added, authorized loans as well as grants under the Hill-Burton program, authorized grants for the country's schools of public health and for civil defense purposes, raised military and VA physicians' pay, and required labor and management health and welfare plans to make reports and open up their books for inspection by members.

American Medical Association was able to persuade the Department of Defense and the administration to retain the post of Assistant Secretary (health and medical) in the reorganization of the department. In legislation passed by Congress to bring about the reorganization, one of the assistant secretary posts would have been eliminated, and the medical assistant was marked for down-grading. However, Secretary McElroy eventually announced that the position would be continued.

Even before Congress adjourned, it was clear that trouble was in sight for Medicare because of inadequate appropriations and instructions from Congress not to exceed the appropriation. To keep within the limitation, if possible, Defense Department was channelling many thousands of service families to military facilities, and at the same time limiting the scope of care permitted in civilian facilities.

DR. STRICKLAND HONORED

Dr. W. A. Strickland, beloved Oconee county physician who has been practicing in Westminster for 51 years, was honored September 2 at the Selective Service Board office in Walhalla.

He was awarded a certificate of appreciation in recognition of 15 years of faithful service to Local Board No. 37 as medical adviser.

Dr. Strickland was invited to the board office where a letter from Lt. Col. James Hunter, State Selective Service director, was read by Sam F. Reeder, a member of the Local Board. Board Chairman W. H. Bolt presented the certificate and a 15-year service pin.

DOCTORS, LAWYERS TOLD ABOUT JOINT PROBLEMS

The director of the law department of the American Medical Association urged better relations between the medical and legal professions in a speech to a gathering of Pee Dee doctors and lawyers on October 18.

C. Joseph Stetler said the two professions have come to recognize that the administration of justice is a joint undertaking. "The difference is in technique—the lawyer attempting to maintain his position by argument and contention and the doctor demanding

a full and frank discussion of all the facts before making a judgment, with reference to illness," he said.

The lawyer has to recognize that the medical profession is a busy one and should arrange for the doctor to spend as little time as possible in the courtroom, he said.

Stetler pointed out that 65 to 80 per cent of all litigation in today's courts require some type of medical reports or testimony and that seven out of ten personal injury cases are decided on medical rather than legal considerations.

"It is appalling to note the unprofessional and unethical action of the few doctors who have become 'professional witnesses' for the plaintiff and defense counsel," Stetler declared. He urged concerted action to eliminate "this new medical specialty."

PEDIATRICIANS INSTALL DR. CASTLES

Installation of new officers of the South Carolina Pediatric Society took place at the Hotel Columbia, following the annual meeting of the society, September 9.

Dr. C. Guy Castles of Columbia took over as president, succeeding Dr. Fred Adams of Spartanburg. Dr. C. H. Zemp of Camden became vice president, replacing Dr. Castles, and Dr. Kenneth Herbert of Charleston became secretary-treasurer, replacing Dr. Zemp.

Special guests at the meeting were Dr. James C. Overall, clinical professor of pediatrics at Vanderbilt University and president-elect of the American Academy of Pediatrics; and Dr. Victor C. Vaughn, III, professor of pediatrics at the Medical College of Georgia.

Other speakers who addressed the convention were Dr. J. I. Waring of Charleston, on "Dysglobulinemia, Case Report On a Child"; and Dr. J. W. Rhodes of Charleston, on "Mumps—Meningo Encephalitis."

DIRECTOR IS NAMED FOR MENTAL CLINIC

Appointment of Dr. H. W. Herbert as clinical director of the Darlington-Florence Mental Health Clinic was announced by Dr. W. P. Beckman, state director of mental health.

Dr. Beckman said that Dr. Herbert would assume his duties on January 1. He will serve as a full-time psychiatrist for the institution, which now is located in Florence and which is expected to move to a site midway between the county seats of Darlington and Florence, near the Tuberculosis Sanatorium.

LeRoy M. Want of Darlington and the Rev. Joseph R. Horn, III of Florence, chairman and vice-chairman, respectively, of the clinic's advisory board, predicted that assumption by Dr. Herbert of his new duties would make the mental health center of even greater value to the two counties. They said that the center hoped to add additional trained personnel from time

to time. Plans are for a \$100,000 center off the Florence-Darlington Highway.

Dr. Herbert was formerly in general practice at Florence, for 19 years. He is now finishing his residence in psychiatry at the University of Virginia Hospital, in Charlottesville. His recent work has included the fields of adult, child and general psychology and neurology.

Between October 15 and January 1, Dr. Herbert will spend some time at Letchworth Village, outstanding training center for mentally retarded children, in New York state.

THE MONTH IN WASHINGTON

For many years a number of students of government have been searching for some way of checking the growth of the Federal bureaucracy and returning certain functions to the states.

Two particularly vexing problems are involved. Because the Federal government has moved into so many taxation areas, states complain that even if they wanted to regain control over certain programs, they would have no way of paying for them. Also, a fool-proof mechanism would have to be devised to insure that the programs didn't break down during the transition and that the states would in fact keep up the activities after U. S. dollars stopped coming.

If the administrative details could be worked out, and if Congress would agree to reverse the trend, a number of U. S. Public Health Service grants programs presumably could be turned over to the states.

President Eisenhower is deeply interested in attempting to turn the tide, and last year the Administration came up with a concrete proposal. It was to make the states completely responsible for the water pollution control operation (\$50 million annually in U. S. grants) and vocational education (\$35 million a year). So the state would have money to finance the work, the U. S. would drop part of its tax on telephone service, inviting the states to levy their own tax.

Congress was cool to the idea. Besides, after giving it more consideration, the then Secretary Folsom of HEW decided it wouldn't work because the low-income states couldn't realize enough from the telephone tax to meet the extra expenses.

But the Administration hasn't given up hope. Supported by the federal-state joint action committee, Secretary Flemming (Folsom's successor) is proposing a new method, one that he thinks will meet the problem of the low income states.

He would shift to the states the same two programs—water pollution control and vocational education. At the same time the U. S. would forego 30% of the present tax it imposes on telephone service and permit the states to levy this amount. In addition, to take care of the poor states the U. S. would allocate among states an amount equal to 10% of the present telephone tax, distributing relatively larger shares to the low per capita income states.

In dollars, as explained by Secretary Flemming, the states would be losing \$85 million in U. S. grants, but they would have an opportunity to collect a total of about \$109 million on telephone service and receive \$36 million in the new grant arrangement.

In announcing that the Administration was going to try again to have this idea adopted, Mr. Flemming emphasized that both programs were of great value and shouldn't be allowed to "drop through the cracks in the floor" during the period of transition. He noted that under his proposal the U. S. could step in and make a state use the money for the specific purpose if it showed an inclination to collect the tax but spend the money somewhere else.

The question now is whether Congress will show any enthusiasm over the plan. At any rate, it will be opposed vigorously by the telephone industry and vocational education interests. The latter are fearful that their programs might suffer under all-state operation.

DR. WILSON WILL HEAD G. P. PHYSICIANS

The South Carolina chapter of the American Academy of General Practice concluded its 10th annual scientific assembly with the election of Dr. I. Ripon Wilson, Jr. of Charleston as president.

Dr. Wilson succeeds Dr. Homer M. Eargle of Orangeburg.

Other officers elected at the two-day meeting were Dr. William T. Hendrix of Spartanburg, president-elect; and Dr. William A. Stuckey of Sumter, vice-president.

Re-elected were Dr. Horace M. Whitworth, Greenville, secretary-treasurer; and Mrs. Inez C. Lytle, Greenville, executive secretary.

Three new directors were named for three year terms. They are Dr. A. Richard Johnston, St. George; Dr. Frank C. Owens, Columbia, and Dr. Robert Quinn, Georgetown.

Dr. Charles N. Wyatt, Greenville, and Dr. Harold E. Jervcy, Jr., Columbia, were re-elected delegates to the congress of AAGP.

The group decided to hold its 1959 meeting October 11-12, at Clemson.

One of the recent additions to the Columbia profession is Dr. James F. Adams.

Dr. Adams is associated in the practice of radiology with Dr. T. A. Pitts.

Dr. Adams is a native Georgian. He earned an A. B. from Emory University and an M. D. from the Medical College of Georgia. Dr. Adams interned and took his fellowship in radiology at Charity Hospital of Louisiana in New Orleans. He is a diplomate of the American Board of Radiology.

They will supply the radiological departments of the Baptist and Providence Hospitals and the State Hospital for mentally ill.

DR. CRAWFORD ADDRESSES AUXILIARY

"Medical men should not only keep well informed as to political actions but should be active participants in politics and public affairs," Dr. R. L. Crawford of Lancaster told a statewide gathering of medical men's wives in Charleston on October 2.

Dr. Crawford, president of the South Carolina Medical Association, was guest speaker at the luncheon meeting held by the Woman's Auxiliary to the South Carolina Medical Association.

Speaking on the topic, "Doctors In Politics And Public Affairs" he discussed the socialistic trends in medical fields abroad and warned of similar trends in the states. He declared that Medical Associations and their Auxiliaries should not only keep informed as to the progress of the Forand bill in the coming session of Congress but should take an active stand on some of its provisions.

Dr. Crawford also told the Auxiliary that the South Carolina Medical Association had received awards in both 1957 and 1958 for contributions to the American Medical Education Foundation. The AMEF was established in 1951 by the AMA, he said, to raise funds within the medical profession for the medical schools.

Mrs. George H. Orvin, Auxiliary president, conducted the business session which preceded the luncheon meeting. Mrs. W. D. Workman, immediate past president, of Woodruff, was elected as nominating committee chairman, with Mrs. E. Gordon Able, Newberry, and Mrs. E. Benton Burns, Sumter, named as committee members.

S. C. CHAPTER OF PUBLIC HEALTH PHYSICIANS ORGANIZED

The South Carolina Chapter of the American Association of Public Health Physicians was organized and a constitution and by-laws were adopted on September 8 when 21 physicians became charter members. It is expected that 8 or 10 additional members will join soon.

The objectives of the organization are to promote better public health in South Carolina through better informed and better trained health officers, through the exchange of ideas and techniques among health officers, and through discussion of mutual health-officer-problems leading toward their solution.

The South Carolina chapter is an organization of physicians who are in full-time public health work in the state, county, or city health departments. Physicians who are part-time health officers in city, county, or state health departments may become associate members. Physicians in full-time employment with the national health organization and who are assigned to South Carolina for a period of duty may become members. The organization will meet 4 times a year.

Officers elected for the first year are Dr. John M. Preston, president; Dr. F. L. Geiger, vice-president; and Dr. G. E. McDaniel, secretary and treasurer.

COLLETON BOARD APPROVES PLANS FOR HOSPITAL

At a recent meeting the Colleton County Hospital Board accepted tentative plans for a 50-bed addition to the hospital. Plans, drawn by John H. Truluck, local architect, have been forwarded to Columbia for approval.

A request was made by the board for an addition of beds due to the crowded condition of the hospital. The county delegation agreed to this, provided taxes were not raised.

A wing will be built to the north of the present emergency entrance that will take care of the X-Ray equipment and dark room; also a class room.

The present X-Ray department rooms will be used by the laboratory which will double its size.

A two-story wing will be constructed on the south end of the present building. The first floor of this will be used for a maternity ward and the second for medical and surgical patients.

There will be a 10-bed addition to the present Negro ward.

DR. BLACKMON OPENS OFFICE

Lyndell W. Blackmon, M. D., has opened an office for the practice of Ophthalmology at 1420 Lady St.

Dr. Blackmon attended Columbia City Schools and the University of South Carolina prior to World War II, served as a parachutist with the 82nd Airborne Division in Europe.

He attended the Medical College of South Carolina following his discharge from service and was graduated in 1950. After internship at Roper Hospital in Charleston, 1950-51, he practiced general medicine in Enoree, until 1955.

He took specialized training in diseases and surgery of the eye in the Tulane University School of Graduate Medicine and the New Orleans Eye, Ear, Nose, and Throat Hospital from 1955 to 1958, and took additional training in eye surgery at the Confederate Memorial Center in Shreveport, La.

He has also attended the Lancaster Courses* in Ophthalmology at Colby College in Waterville, Me.

GROUP NAMES DR. F. R. PRICE

Dr. F. Raymond Price of Charleston has been elected president of the South Carolina Ophthalmology and Otolaryngology Society.

The election took place September 16 in Asheville, N. C., at a convention of eye, ear, nose and throat societies of North and South Carolina.

Other new officers include Dr. Robert E. Livingston of Newberry, vice president; Dr. Roderick MacDonald of Rock Hill, secretary and treasurer; and Dr. L. D. Lide of Florence, president-elect.

DR. ALTMAN OPENS ST. GEORGE OFFICE

Dr. James L. Altman has opened an office for the

general practice of medicine in the Judy building on Main Street, St. George.

A native of Charleston, Dr. Altman is a graduate of the Medical College of South Carolina. He attended The Citadel one year and graduated from the University of South Carolina, where he took postgraduate work in psychology. He interned at the Regional Hospital in Orangeburg.

Dr. Altman served from 1941 to 1945 in the U. S. Navy, two years of which time were spent in Russia. He was also stationed in the Mediterranean area for sometime.



"I'll Have To Have Your Complete Case History. How Much Were You Paying Doctor Watkins?"

ANNOUNCEMENTS

A. M. A.

CLINICAL MEETING
MINNEAPOLIS, MINNESOTA
DECEMBER 2-5, 1958

BAHAMAS CONFERENCES

Serendipity—Peace of Mind—Not to have to watch the clock: Nassau.

This coming winter, there will be three Conferences: The Sixth Bahamas Medical Conference, November 28th until December 18th; The First Bahamas Surgical Conference, December 29th until January 17th; The Serendipity Session, January 18th until January 31st, 1959.

The British Colonial Hotel where all sessions will be held, has made it possible for participants and their parties to avail themselves of the facilities of the fully redecorated hotel at reduced rates, PROVIDED THAT RESERVATIONS ARE MADE BY WRITING DIRECTLY TO BAHAMAS CONFERENCES, P. O. Box 4037, Fort Lauderdale, Florida, Telephone Jackson 3-7303 at Fort Lauderdale, Florida, and NOT through agents.

DEATHS

DR. WILLIAM U. GUNN

Dr. William U. Gunn, 38, clinical director of Whitten Village in Clinton, died September 16 at Self Memorial Hospital in Greenwood after a few days illness.

Dr. Gunn, a native of Harlan, Ky., was a graduate of the University of Kentucky, and the University of Kentucky Medical School. He was associated with hospitals at Orlando, Fla., New Orleans, La., and Lexington, Ky., before coming to Whitten Village.

DR. W. H. CHAPMAN

Dr. William Herbert Chapman, 77, of Whitney, died at his home September 24 after a long illness.

Dr. Chapman was Spartanburg County's Doctor of the Year in 1950. He had practiced medicine in Whitney and surrounding areas for approximately 50 years.

INFORMATION

U. S. ATOMIC ENERGY COMMISSION RADIOLOGICAL ASSISTANCE PLAN

POINT OF CONTACT: In the event of an incident involving radioactive materials, IMMEDIATELY contact the:

U. S. Atomic Energy Commission
Savannah River Operations Office
Aiken, South Carolina

Augusta, Georgia
4-6372, Ext. 3333

or

Aiken, South Carolina
9-6211, Ext. 3333

Call collect, if necessary

POSSIBLE INCIDENTS: In your state, incidents involving radioactive material will almost without exception arise from one of two sources.

1. Material being transported within or across the state by either motor freight, railroad or airplane.
Regulations require that trucks and railroad cars transporting radioactive material bear a placard denoting the presence of hazardous materials. Also, all packages containing radioactive material, including those shipped by air, are appropriately labeled to denote the contents are radioactive.

2. *AEC Licensees.* These are laboratories, hospitals, colleges, private firms and individuals licensed by AEC to receive, store and use radioactive material.

AEC ASSISTANCE TEAM: A team of radiological assistance specialists stands ready, 24 hours a day, to respond to any request for assistance. The team is comprised of radiation monitoring experts, radiation-trained doctors, and public relations specialists, under the direction of a key AEC official. Equipped with radiation monitoring and detection instruments, clean-up equipment, protective clothing, walkie-talkies, etc., the team can move out on short notice, by commercial or charter aircraft if necessary, to the location of any incident that might occur in your state.

PROMPT NOTIFICATION: The key to the AEC Assistance Team being able to do its job on any radiation-connected emergency is PROMPT NOTIFICATION. The first state, county, or municipal official on the scene should IMMEDIATELY telephone the AEC Assistance Team at one of the numbers listed above.

AEC-RECOMMENDED PROCEDURES FOR USE BY LOCAL AUTHORITIES IN DEALING WITH INCIDENTS INVOLVING RADIOACTIVE MATERIALS

If radioactive materials are involved in incidents causing their spillage or release:

1. Notify immediately the Savannah River Operations Office of the Atomic Energy Commission. The telephone number is Aiken, S. C., 9-6211, Ext. 3333; or Augusta, Ga., 4-6372, Ext. 3333.
2. If any person is alive and trapped in wreckage, make every effort possible to rescue him.

If immediate actions in the involved area are necessary for the preservation of life and health, minimum contact with the radioactive materials by emergency personnel may be allowed if you observe the following precautions: --

1. Restrict area of accident. Keep public as far from scene as practical. Souvenir collection should be forbidden.
2. Segregate and retain those who have had possible contact with the radioactive material until they can be examined further. Obtain names and addresses of those involved.
3. Remove injured from area of accident with as little contact as possible and hold at a transfer point. Take any measures necessary to save life, but carry out as *minimal* first-aid and surgical procedures as possible until help is obtained from radiological team physicians or other physicians familiar with radiation medicine. DO NOT take injured to local hospital or doctor's office unless certain that he is not contaminated with radioactivity.
4. In incidents involving fire, fight fires from upwind as far as possible, keeping out of any smoke, or dust arising from the accident. Treat the fire as you would one involving toxic chemicals. Do not handle

suspected material until it has been monitored and released by monitoring personnel. Segregate clothing and tools used at fire until they can be checked by radiological emergency teams.

5. In the event of a radiological incident involving a vehicle accident, detour all traffic around scene of accident. If not possible, move vehicle shortest distance necessary to clear right of way. If radioactive material is spilled, prevent passage through area unless absolutely necessary. If right of way must be cleared before AEC radiological assistance arrives, wash spillage to shoulders of right of way with minimum dispersal of wash water.
6. Do not eat, drink or smoke in the area. Do not use food or drinking water that may have been in contact with material from the accident.
7. Take only the minimum, necessary steps prior to the arrival of radiation specialists and physicians.

Experiences With Some Common Mammalian Bites.
Karl M. Lippert (Columbia) Tri-State M. J. 6:16 Aug. 1958.

Evolution from rural to urban life and mechanization has diminished usual contacts between man and other mammals. When man is bitten by man or by an animal, infection in the wound is the most likely sequel. Although each mammal bite may have peculiar characteristics, the basic principle in the treatment consists of intensive washings with soap and water, debridement, and simple gauze dressing. Delayed wound closure in most instances is advisable. Although many bacterial organisms have been found in various bite wounds, it appears that the infrequently cultured *Pasteurella* family are the significant organisms to be found in this type of wound infection. The wide distribution of *Pasteurella* in mammals was presented in chart form with notes on the appearance and cultural characteristics of this bacterial family.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. George Orvin, Charleston, S. C.

Corresponding Secretary: Mrs. John Cuttino, Charleston, S. C.

The Fall Board Meeting of the Woman's Auxiliary was held in Charleston, October 2, 1958 at the Fort Sumter Hotel. The meeting was conducted by Mrs. George H. Orvin, President, and after the business session Dr. R. L. Crawford, President of the S. C. Medical Association talked to the ladies on "Doctors in Politics and Public Affairs."

Dr. Crawford brought to the attention of the wives that they and their doctor husbands should be aware of what legislative bills were passed and what were not. He placed particular emphasis on progress of the Forand Bill in the coming session of Congress. He discussed the Socialistic trends in medical fields abroad and warned of similar trends in the states. Dr. Crawford also told the Auxiliary that the South Carolina Medical Association had received awards both in 1957 and 1958 for contributions to the American Medical Education Foundation. The AMEF was established in 1951 by the A.M.A. to raise funds within the medical profession for the medical schools. Industry had been contributing to colleges and medical schools for sometime, and the physicians felt it time that they take on their share of the responsibility. In this light he asked that the doctor's wives encourage their men to give to A.M.E.F.

Mrs. Orvin has selected the AMEF as the Auxiliary's main project for the year. Through "In Memoriam" and "In Appreciation" giving AMEF could be greatly benefitted. Also, Mrs. Orvin has secured several clever ideas to pry loose the pennies. Along with the usual raffles and donations there is one idea

to assess everyone a certain coin or two per pound weight. That should bring interesting results. With it all, and each county auxiliary's plan for AMEF, the results at the end of the year should be astounding.

There has been a great deal of work on Nurse Recruitment in the last few years. The doctor's wives have assisted the nursing schools throughout the state in preparing and presenting information about the nursing schools and nursing as a career to the high school students in South Carolina. The Future Nurses Clubs have been organized and sponsored by the Auxiliary. Last year 200 girls attended the two day Future Nurses Club Rally held at Winthrop College. The Medical Auxiliary has done a great service to the hospitals and nursing schools in this state. At this time there are few schools that do not have their quota of student nurses. The Future Nurses Club Rally at Winthrop in February, 1959 will be handled by Mrs. Max Culp, Fort Mills, S. C.

Another project of the Auxiliary is the Student Loan Fund established to assist financially the men and women who wish to receive their medical education in South Carolina. Safety, Civil Defense, and Mental Health are self explanatory. Each auxiliary member is made aware of the necessity of understanding and working for the betterment of safety, civil defense and mental health.

Attending the Board Meeting in Charleston, were the county presidents, past presidents, and members of the Executive Board.

Lucia C. Heins

THE OFFICIAL SEAL OF THE SOUTH CAROLINA MEDICAL ASSOCIATION



PRESENT SEAL



SUGGESTED SEAL

Designed by
Mrs. Hal Powe, Jr.
Greenville

WHICH DO YOU PREFER?

BOOK REVIEWS

INTERNATIONAL SOCIETY OF HEMATOLOGY. Grune and Stratton Company; New York, 919 pages; 1958. Price \$25.00.

This is the sixth volume in a series covering the meetings of the International Society of Hematology and is a review of the papers presented at the 1956 meeting in Boston. It has been ably edited with the inclusion of either abstracts or complete papers of 370 contributors.

The subdivisions of leukemia, nucleonics, spleen and hypersplenism, hemorrhagic disorders, anemia, immuno-hematology, and miscellaneous are covered with an excellent review of the basic research in progress as well as the clinical applicability. The increased significance of radio-active methods in the study of the red cell is emphasized as well as the deleterious effect of radiation to the hemopoietic system. Although much of the material loses its value

in being published two years after presentation, it still gives an excellent source of reference for the newer developments in hematology.

This volume is a necessity for every hematologist or hematological laboratory and should be available for inspection by all practitioners.

Charlton DeSaussure, M. D.

THE PSYCHOLOGY OF MEDICAL PRACTICE, by Mark H. Hollander, M. D., W. B. Saunders Company, 1958. Price \$6.50.

This monograph consisting of 262 pages of text, with an excellent subject index, has been produced by Dr. Mark H. Hollander in collaboration with Dr. Leonard A. Stein, Assistant Professor of Clinical Medicine, Chicago Medical School; Dr. Ernest M. Solomon, Instructor, Department of Obstetrics and Gynecology, Northwestern University Medical School, and Dr. Julius B. Richmond, Professor and Chairman of the Department of Pediatrics of the State University of New York, Upstate Medical Center, Syracuse, New York.

Dr. Hollander and his collaborators have attempted to turn a psychological spotlight on the patient, the physician, and the medical situation in regard to problems encountered in the everyday practice of medicine, and to suggest some approaches in the management of these situations. Dr. Hollander shifts his emphasis from a consideration of conscious difficulties which can be understood at a commonsense level to unconscious problems which the author treats in the framework of the psycho-analytical type of approach. It is an attempt to provide a book which may give a clue to some understanding of the so-called "doctor-patient relationship" and to verbalize some of the thoughts which he and others have had concerning the "art of medicine" as distinct from the "science of medicine".

The contents are presented in distinct sections by chapters, and cover the doctor-patient relationship, some thoughts concerning the management of medical patients, patients with carcinoma, patients undergoing surgical treatment, obstetrical patients, problems related to the care of children in health and in disease and with their families under both circumstances, and psychological considerations in the use of medications, and a section on non-medicinal prescriptions.

The problems covered are of commonplace occurrence and certainly merit consideration and thought, not only as a means of awakening ideas of this sort in the minds of a busy medical student or house officer or beginning practitioner, but also the perusal of a volume of this sort is of value to one already established in practice from the standpoint of letting him re-think and remember how he himself may have handled some of these very frequently encountered and often highly emotionally charged areas in the field of medical practice in general.

Some may find areas of disagreement with the various approaches presented, and certainly it would be beyond the realm of human endeavor to write a perfect book of this sort, but in these pages one will find thought-provoking and soul-searching questions which should help the neophyte in medicine to develop patience with patients and their families, and serve to enrich the more philosophically inclined in the older, established practitioner group who may peruse its pages.

In general, one may sum up the situations of the doctor-patient relationship as presented in this small volume as pointing out that there are areas in medical practice where scientific knowledge permits a doctor to give straightforward, dogmatic guidance based on medical knowledge. In other areas guidance will be based on moral and religious foundations, and in other areas the patient and the family are to be helped in their thinking so that they realize the decisions which they have reached are of their own choosing and arrived at as wisely as they themselves can achieve them.

Dr. Hollander's thoughts may be summed up in

not only "know thyself" but even more one must know the patient more than superficially.

Vince Moseley, M. D.

THE OPERATIONS OF GENERAL SURGERY. G. A. Higgins and T. G. Orr. W. B. Saunders Company, Philadelphia. 1958. Price \$20.00.

This is a one volume work covering the field of general surgery in the broad sense of the term. It gives in a clear outline fashion established techniques for operations upon the abdominal and thoracic cavities and the head and neck. Cardiac and pulmonary surgery are included. The text is well supported by excellent illustrations. The purpose of the operation is stated and physiologic and pathologic considerations are briefly but clearly given. It should serve as a valuable reference for internists, general practitioners, and students who wish to obtain a knowledge of the application of surgical procedures to the various diseases. The technical descriptions are clear and sufficiently complete to be of great assistance to the general surgeon.

Dr. T. G. Orr, the author of the first two editions, died shortly after he had begun work on the third edition. The revision was completed by Dr. George H. Higgins and Dr. Thomas G. Orr, Jr.

William H. Prioleau, M. D.

PROGRESS IN PSYCHOTHERAPY. Volume 3, Techniques of Psychotherapy. Edited by: Jules H. Masserman, M. D. and J. L. Moreno, M. D. 310 pages. Grune and Stratton, New York—Cost: \$8.50.

In 1954, the first organized meeting of the Section on Psychotherapy of the American Psychiatric Association took place in St. Louis. This Section presented a program at the next annual meeting of the A. P. A., in 1955, and subsequently, it was decided to publish the proceedings of the Section on Psychotherapy. In addition, the volume published would contain contributions not necessarily presented at the Section's meeting. Further, the editors would invite psychiatric leaders in certain foreign countries to contribute surveys of psychotherapy in their countries. Thus, the volume was meant to present an annual survey of the world situation in psychotherapy.

The present volume is the third presentation of *Progress in Psychotherapy*; Dr. Masserman is co-editor of this volume. Dr. Moreno has been one of the co-editors since the publication's inception.

This volume is separated into five major parts: I. History (of psychotherapy). II. Rationale and Methods. III. Special Techniques. IV. Psycho-pharmacology. V. Developments Abroad.

The wide variety of techniques described and the summary nature of the presentations make this an excellent source book for a perspective view of the field of psychotherapy but it certainly cannot be used as a textbook for any of the specific techniques described.



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symptoms
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*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

SEARLE

TODAY'S CHALLENGE



Doctors are generally agreed that the best hope of saving lives from cancer is early detection and prompt, proper treatment. Great progress has been made in the last ten years: the saving now of 1 in 3 compared with 1 in 4, as more and more people are seeing their doctors **in time**.

But with present knowledge and existing facilities, it is possible **today** to save **1 in 2** cancer patients. This is the target of the American Cancer Society's professional and public education programs.

The Society offers doctors a variety of free services: **Literature:** two bi-monthly magazines; **Films:** 200 available on loan, including a series of kinescope films covering practically every clinical phase of cancer; **Slides:** (In color) Characteristic early lesions in sites of greatest incidence; **Exhibits:** for medical meetings and conventions, on special aspects of diagnostic and therapeutic problems.

In its public education program, the Society uses every effective communication medium to urge people to have annual health checkups and to go to their doctors promptly at the appearance of a danger signal.

The challenge will be met. As more and more doctors' offices become "cancer detection centers," and as more and more people see their physicians regularly, the closer will come the day when half of our cancer patients will be saved. The know-how for saving the remaining half is still being sought in our research laboratories. Ultimately that challenge, too, will be met.

AMERICAN CANCER SOCIETY



Excellent summaries of a wide variety of special techniques are given. Among them are Music in Therapy, Group Interaction through Dance, Psychotherapy in Nursing, Psychiatry and the Ministry, Therapy of the Adolescent, Marriage Counseling and a particularly interesting presentation concerning the Family Group and Family Therapy. In this last, the long-recognized fact that the individual and his emotional illness cannot be separated from the complex, interacting relationships existing in his family group is highlighted. The placing of "the patient" into the larger perspective of the family group brings to light many dynamic forces which can be very useful (when properly understood and applied) in stabilizing a disturbed person. It is pointed out that families can be regarded as "patients," that families have a natural history, that families are dynamic, living things, that families vary as to their assets and liabilities and as to their adaptability to stresses. Further, there are families which are relatively "sick" and families that are relatively "healthy," emotionally speaking. Often, an understanding of the dynamics of a family can make it possible to utilize therapeutic forces within the family for healing effect on a "sick" member.

The therapeutic technique known as Psychodrama comes in for its share of exposition in this volume—perhaps more than its share. This latter seemed to me to be true of the preceding volumes as well. Perhaps this can be understood easily, since, in a sense, Psychodrama is fundamentally exhibitionistic anyway. Still, this "living, breathing" technique is such a refreshing change from certain stereotyped, frequently stultified, over-intellectualized, so-called "analytic" techniques that we can easily forgive its exhibitionism, as if exhibitionism needed to be forgiven at all—which it doesn't. But, don't try to read this book and then open up your psychodramatic workshop. In Dr. Moreno's hands or in the hands of therapists who have undergone training and preceptorship, I am convinced that it can probably frequently work near miracles in the favorable modification of emotional and behavior patterns. But, in any other hands, I am also convinced that beautiful and poignant reality and a work of art simply become just another bad play.

Naive users of "drug therapy" will get an eye opener in the comments referable to the psychological implications of administering medications, to anyone by anyone, anywhere, at any time. The next time you are convinced that a drug you gave a patient "helped" him, pause to reflect that the drug *may* have been the least important facet in the network of phenomena which brought about a favorable change in the patient. And don't try to "use psychology" to "fool" the patient into "thinking" he's "well." Don't forget, you can be "fooled," too, by drugs.

Russia is a country in which we are all interested today. The section in this book describing the status of psychotherapy in Russia is interesting. The flat

statement is made that "the basis of all psychotherapeutic techniques is the same, namely, suggestion—whether in hypnosis, or during the natural state." In no uncertain terms, it is stated that Soviet psychiatry is based upon the principles laid down by Pavlov. "Freudianism" is rather summarily handled by stating that it "is explained as an effect of suggestion."

Running all through this book, although not often specifically stated, is the realization that very little, if anything is known about "how psychotherapy works." This fact need not dismay us, since the same is true of much larger a segment of medicine and surgery more often than it is false. Also, our non-psychiatric colleagues would, should they have to suddenly give up all their "empiric," "non-specific," "symptomatic," "supportive," etc. methods of therapy, find themselves "ridden out of town on a rail" by their suffering patients.

Lawson H. Bowling, M. D.

SCIENCE AND PSYCHOANALYSIS (Volume I. Integrative Studies) J. H. Masserman, M. D., Editor. 194 pages—Price \$5.75. Grune & Stratton, Inc., New York 1958.

Two years ago an interesting development occurred in the psychoanalytic movement, when a new accrediting organization was established for psychoanalysts, called The American Academy of Psychoanalysis. This group consists of the schools of psychoanalytic thought and training known as the Ego Psychoanalysts. It was a culmination of a movement to counter the tendency for a new group of scientific endeavor to pre-empt themselves as an exclusive circle, which, in the words of the preface to this book, "tends after a period of inspiration and expansion to become obscured by dogmatism, incrustured with rituals or pre-empted by a reclusive circle of self-appointed hierarchs."

This book contains 76 articles by a variety of psychoanalysts from the various schools or those sympathetic with their ideals. It has attempted, in a very scholarly fashion, to open up the entire field of psychoanalysis, to have the medical profession made aware of the tremendous advances that have been going on, to enlarge the original ideas of Freud. It is not a vindictive polemic against Freud, but is based on the basic healthy attitude, "People are never really basically wrong—they merely never realize how far they haven't gone."

In other words, it attempts to demonstrate that the major contributions of Freud to the theory of practice of psychoanalysis originally started on very sound scientific and medical ground, but that many of his followers were unable to free themselves from theory and hypothesis, thereby stultifying further research and development in this very important field.

The breadth and scope of the various articles are such that it is difficult to summarize in a few words the theme of the book, except to say that the major

emphasis has been with developing and improving and extending the technique of psychoanalysis, which, after all, is our main function. The original basic technical developments by Freud remain unsurpassed today. The four pillars of psychoanalytic practice rest on:

- 1—Free association, which is the spontaneous penetration of unawared feelings.
- 2—The deciphering of the vast numbers of symbols in dreams—is the “via regia” to the real truth of ones feelings as represented in the unconscious.
- 3—The neurotic relationship of the patient to the analyst that soon appears in therapy, called “the transference phenomenon.”
- 4—Resistance, the blocks and obstacles and sabotage efforts that the patient uses to prevent the analyst from seeing the patients real feelings.

The book basically starts on these premises and attempts to elaborate the various ways and means of the basic tools of psychoanalysis, without the unnecessary, unwieldy superstructure of pseudo-theories.

This book is particularly recommended for the entire medical profession since it is written in common sense terms, is highly readable, and represents a classic textbook in the growing literature of Ego Psychoanalysis.

Norton L. Williams, M. D.

OPHTHALMIC PLASTIC SURGERY (Second Revised Edition). Sidney A. Fox, M. D. Grune and Stratton, New York, 1958. Price \$15.00.

It is the author's stated intent to write a practical book for the practitioner based on his own experience. He has done this honestly and well, stating the limitations of procedures as he has found them in his broad experience rather than portraying a few good results as typical.

In discussing the advantages of surgery over x-ray in the treatment of malignant growths of the lids, he lists five important points of superiority. With surgery one has a tissue diagnosis, a known margin of excision, better cosmetic and functional result, together with freedom from serious radiation effects such as conjunctival keratosis and the necessity of using extensive x-ray therapy for recurrences.

Most of the operative procedures recommended are standard but show the influence of personal experience and sound judgment. In several areas, however, the reviewer's opinions run counter to those of the author. Lateral displacement of the medial canthus usually requires a most firm attachment with wire sutures to the nasal bones rather than just to the periosteum in order to correct this defect permanently.

In elevating a depressed globe, the author recommends a skin incision just below the orbital rim. Better concealment of this incision is made by placing it just below the free margin of the lid with no sacrifice in case of approach. Although treating the subject of a depressed globe and methods of its elevation, no mention is made of the accompanying diplopia or its correction. His reconstruction of the lower lid could be much improved by utilizing a lateral cheek or temporal flap rather than by superior advancement of a cheek flap. For the replacement of the tarsal plate, he recommends preserved cartilage grafts. These are not reliable, frequently being absorbed by the host. Autogenous auricular grafts taken from a properly selected area of the concha are much more dependable and are of excellent contour and are available in satisfactory quantity.

The author dismisses as a shibboleth the widespread misconception that skin grafts and mucosa in the same globeless socket lead to dire results.

In summary, this is a most complete and honest appraisal of ophthalmic plastic surgery and is well worthy of careful study by all interested in this field.

Robert F. Hagerty, M. D.

NEGROES AND MEDICINE—Dietrich C. Reitzes. Published for the Commonwealth Fund by Harvard Univ. Press, Cambridge 1958. Price \$7.00.

This is an extensive survey covering 14 communities scattered over this country. It discusses negro applicants to medical schools, negro medical students, relation of negro hospitals to community patterns, integration and the approaches used to achieve it, and various other facets of the subject. Statistical studies are accompanied by much comment but no comprehensive conclusion. The book is a special contribution to a general field of discussion which is still in a state of turmoil.

J. I. W.

PROGRESS IN CARDIOVASCULAR DISEASES. Edited by Charles Friedburg, M. D. Grune & Stratton, Inc., New York. Subscription, \$8.00 a year.

This is a new quarterly publication intended to contribute to postgraduate education in this field.

It is an excellent review of the advances in cardiac surgery. It will be of great interest to the cardiovascular specialist and probably the internist, but not to the general physician.

In view of the rapid advances in cardiovascular diseases and voluminous literature such a publication will aid to keep many abreast who are not near a large medical center.

P. Gazes, M. D.



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SERUM CHOLESTEROLS IN AN OFFICE PRACTICE

A. IZARD JOSEY, M. D.
Columbia, S. C.

In the past decade much has been written and much has been said concerning the relationship of fat in the diet to the level of cholesterol and various lipoprotein molecules in the blood serum to the incidence and etiology of atherosclerosis and its complications of cardiovascular disease, coronary sclerosis and myocardial infarction. Using statistical analysis of mortality and morbidity indices of various countries, Keys and associates¹ have proven to the satisfaction of many that in areas where the fat content of the diet is only 20 per cent or less of the total calories consumed atherosclerotic complications such as coronary thrombosis are practically nonexistent. Further, in countries in which the caloric consumption from fat is as high as 35 to 45 per cent the incidence of coronary atherosclerosis is quite high. Studies by the Keys group¹ have produced evidence that the average serum cholesterol levels in populations existing on a low animal fat diet are considerably lower than the cholesterol levels of a population who consume a diet having a high animal fat content. This same group of investigators² also claim that this is not due to ethnic origin, as shown in a comparative study of Japanese living in Japan, Hawaii and California and presumably consuming the customary diet of these different geographical areas. It has also been found that herbivorous animals such as rabbits, rats and guinea pigs fed on a diet containing additives of cholesterol develop arterial lesions similar to but

not exactly like those seen in human atherosclerosis.³ The development of myocardial infarction as the culminating complication in such experimental animals is not so easily accomplished and has been reported in only one study by Hartcroft and Thomas.⁴ They used rats on a diet high in saturated fats and cholesterol with cholic acid and thiouracil added.

Ahrens and co-workers⁵ have cast some doubt on the application of such statistical and animal experimental evidence to the solution of the problem of atherosclerosis and its complications in the human. Extensive reports have appeared to indicate an increased serum level of lipoproteins of various densities in known cases of coronary disease in man.⁶ Originally the hypothesis was advanced that an increase of B lipoprotein molecules of the density $Sf^{\circ} 12-20$ was the important factor, later the B lipoproteins of $Sf^{\circ} 10-100$ density were incriminated. For a period of time serum cholesterol levels were accepted as reflecting the levels of B lipoproteins of these densities. More recently the correlation of serum cholesterol and these B lipoproteins is being denied by some as not sufficiently closely correlated and practitioners are being advised by certain publications⁷ to have B lipoprotein studies done on patients to determine their prognosis in regard to atherosclerotic complications. However Lowy and Barach⁸ in a recent study of a large group of diabetic patients reiterate that the cholesterol level is as

good or better than the B lipoprotein molecules as a predictor of atherosclerotic complication. Doubts as to the predictive value of the serum cholesterol level in evaluating the extent of atherosclerosis in an individual and its value as a prognostic index of coronary thrombosis in the human has been expressed by Page, his co-authors⁹ and by Ahrens.⁵

Except in cases of hyperlipemia the consistent reduction of increased serum cholesterol levels by dietary measures has not been highly successful. At first animal fats were described as the incriminating agent and unsaturated vegetable fats were substituted. It was later determined that when liquid vegetable fats were solidified the process of hydrogenation produced a lipid that was as noxious as the saturated animal fat and hence margarine and superheated corn oil were taboo in cholesterol - reducing diets. Other measures to reduce serum cholesterol levels in humans have been advanced. Oliver and Boyd¹⁰ demonstrated the cholesterol lowering effect of estrogens and Engelberg, Kuhn and Steinman¹¹ cited the effect of heparin in lowering cholesterol levels and clearing lipemia. Parsons and Flinn¹² demonstrated the cholesterol - lowering effect of extremely high doses of nicotinic acid. For various reasons the use of such methods has not as yet found any wide practical usage.

Two articles recently report the reduction of levels of serum cholesterol in man. Farquhar and Sokolow¹³ report consistent lowering of cholesterol levels in a group of 15 people, 13 of whom had atherosclerosis, when given safflower oil, 81 grams, substituted for equal amounts of saturated or hydrogenated fat, or 18 gms. (90 ml.) B sitosterol daily while on their usual diet. There was an increased lowering effect when the two substances were given in combination. In addition these writers found there was a correlative change in the B lipoprotein levels. Nothman and others¹⁴ reported a reduction in cholesterol levels in 21 patients who had hypercholesteremia when 25 ml. of a mixture of unsaturated vegetable oils was added to the usual diet. However Perkins and Wright¹⁵ gave a group of 24 normal young men 75 ml. (48 Gm.) of safflower oil daily while they

were consuming the usual American diet containing an average of 42 per cent of its calories in fats that were largely saturated or hydrogenated. Comparing the period to a control period there was no lowering of the cholesterol level in this group. Rivin and co-workers¹⁶ did monthly determinations for 6 to 12 months on a group of 10 patients with coronary disease who were on a diet containing 30-40 per cent of the calories in fat. Using 5 different laboratories they found quite a wide variation in results, from 172-312 mg./100 ml. of cholesterol on one serum. In their own laboratory there was a variation of 16 per cent, more or less, on duplicates. Rosenman and Friedman¹⁷ in doing bimonthly serum cholesterol values on a group of 42 accountants for a 6 month period found a rather consistent rise of 100-125 mg. during stress periods of 1-15 January and 1-15 March. Of interest in relation to the "stress" factor as an agent in the production of atherosclerosis is an article by Myasnikov, a Russian experimenter.¹⁸ This author used one group of rabbits fed on a diet containing cholesterol, a second group fed on a similar diet with amphetamine added and a third group with phenobarbital added. All showed evidence of sclerosis of the aorta at autopsy but the amphetamine group showed more extensive changes than group one and the phenobarbital group less than group one.

Table 1: Serum Cholesterol determinations in mg. per 100 ml. on 24 male patients not exhibiting any clinical evidence of atherosclerosis.

Case	Age	Determinations
1.	44	142
2.	42	160-329-329-262-312-238
3.	39	160
4.	45	190
5.	41	190
6.	48	190
7.	58	196
8.	50	193
9.	58	156-319-212
10.	53	200
11.	64	200
12.	34	219-275-185
13.	48	250
14.	42	250
15.	45	264
16.	50	269
17.	66	278
18.	37	243-275-270
19.	47	262-277
20.	51	285-285-319-324
21.	45	308
22.	46	310-257
23.	49	310-210-207
24.	58	349-223-176-223

Because of the varied testimony and opinion expressed in the literature by investigators from large and highly placed clinics and laboratories the clinical applications in an office practice of the theories regarding dietary fats and additives of unsaturated fatty acids and serum cholesterol levels appeared to be of the ultimate importance. In an attempt to gain some personal experience serum cholesterol levels were determined on a number of private office patients over a period of approximately the past year. One or more determinations have now been made on 59 patients (56 white men, 1 negro man, 2 white women, all in middle or later period of life) totaling 216 determinations. The Bloor method employing the Lietz Photometer was used and all collections

Table 2: Serum Cholesterol determinations in mg. per 100 ml. on 35 cases having complications of atherosclerosis.

Coronary Thrombosis: 15 males, 2 females, occurring previously or in year 1957-58:

Case	Age	Determinations
1.	57	156
2.	58	156-219-243-262-257-223-257-316
3.	49	160-216-187-174-174-222-199
4.	68	170-150-207-200-219-177
5.	74	180-113-140-173
6.	66	185-190-238-192-185-177-193
7.	63	212-200-243-270-223-238-223-243
8.	40	219-200-285
9.	52	230-278-285-262-219
10.	46	250-230-254-243-255
11.	58	250-278-262-278-238-223-255-195
12.	58	260-204-278-319-223-238-230-200-277
13.	57	270-200-319-219-217
14.	68	270-310-280-354
15.	58	295-259-250-308-316
16.	55	310-282-257-207-277-243
17.	58	319-275-270-246-290-299

Coronary Insufficiency: present and continuing

18.	58	174
19.	61	180
20.	71	185
21.	58	190
22.	52	235-217
23.	66	257-270-237
24.	78	292-257-255
25.	54	292-300-396-379-300-223-292-409
26.	57	300-243-270-278-243-238-190-277
27.	57	379-262-243-300-292-180-223-193-207-218

Cerebral Thrombosis: occurring in 1957-58

28.	79	220-165-155
29.	66	319-110-257-190-243

Symptomatic Peripheral Arteriosclerosis Obliterans: present and continuing.

30.	59	243-165-183
31.	49	243-270-310-310-329-292-400-243-290
32.	59	262-262-285-279-269
33.	72	270
34.	57	280-207-185-285-238-246-219
35.	45	285-212-222

of blood were obtained in the mornings after a fasting period of at least 12 hours. All but a few determinations were done in my office laboratory and with only a few exceptions by the same technician who was personally instructed and checked by an accredited clinical pathologist. Checks against a known standard were determined at sufficiently frequent intervals to control accuracy and a correction factor applied. This factor was always less than 10 per cent. No attempt was made to obtain a real control group, but 24 of the 59 cases have not presented any clinical evidence of atherosclerosis. Of these 24 cases without clinical atherosclerosis, 11 had one or more serum cholesterol determinations of 250 mg. or below and 13 cases had one or more determinations of above 250 mg. (Table 1) or approximately half in each group. The remaining 35 cases had definite evidence of one or more of the complications of atherosclerosis. Of these 35 cases 17 had one or more determinations of 250 mg. and above and 18 cases below 250 mg. (Table 2), again approximately one half

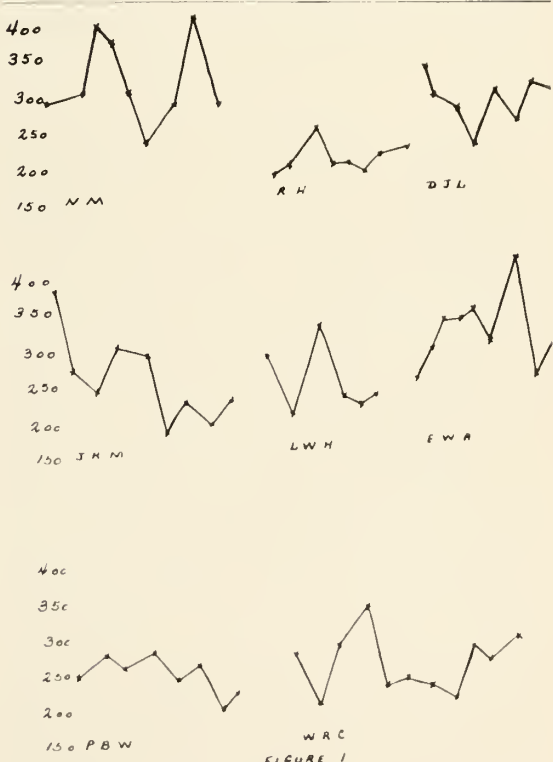


Figure 1

Serum Cholesterol determinations in mg. per 100 ml. on 8 illustrative cases, taken at approximately monthly intervals, on a low saturated, high unsaturated fat diet.

in each group. Where several determinations varied above or below 250 mg. the average figure determined the group placement. Eight cases with myocardial infarction fell into the group with cholesterol levels above 250 mg. and 9 cases of infarction occurred in the group with cholesterol levels below 250 mg.

Sixteen cases chosen for their motivation and ability to cooperate were maintained on a low animal fat diet with instructions to consume no more than three eggs weekly, nor more than 1 pat of margarine daily, no gravies or fat meats and to use skimmed milk. Corn oil for salads and frying was prescribed and in addition a preparation containing linoleic acid 13.6 Gm., Vitamin B₆ 1.2 mg. and Vitamin E 23 mg. per 30 ml. in amounts of 15-30 ml. daily was regularly prescribed for from 5 to 12 months. The total caloric intake was adjusted in each case to obtain or maintain an optional weight. These 16 cases had serum cholesterol determinations at intervals of one month or more for a total of 5 to 10 determinations. Of these 16 cases 12 had no significant changes in serum cholesterol levels and 4 cases showed a tendency to a lowered level but this has not been consistent or persistent (Figure 1).

Discussion: If there be truly a close relationship between the fat content of an individual's diet and the serum cholesterol level and the development of atherosclerosis with its complications, this should be of tremendous interest and of great practical value to the practitioner and to his patients. From the literature there appears to be little controversy that populations who subsist on a diet low in fats, and particularly animal fats, do have relatively low serum cholesterol levels and suffer a minimum from the complications of atherosclerosis. The reverse is purported to be true in countries where the diet is high in animal and hydrogenated fats and where total fats provide 35 to 45 per cent of the total calories consumed. Under closely controlled conditions in a group of atherosclerotic patients with almost total substitution of unsaturated vegetable fats, with or without the addition of B sitosterol, it has been demonstrated that serum cholesterol levels will be reduced. In the practice of medicine this type of program would be almost im-

possible to follow for a prolonged period of time in patients who have gustatory discrimination. Besides this factor the present cost of such unsaturated fats is prohibitive to all but the wealthy. Unless and until such a regimen provides more proof of clinical success it would not be acceptable to the average patient.

An analysis of the data collected on this reported group of patients fails to develop any conclusions that single or serial determinations of serum cholesterol levels would indicate the presence of atherosclerosis or its complications. The levels of serum cholesterol vary so widely in the obvious cases of atherosclerosis that certainly it can be said that a single determination in any case of suspected or known atherosclerosis would be of no value in determining what is being called the "atherosclerotic index". The group of 16 patients with known atherosclerosis who were directed to live on a low saturated fat diet with added unsaturated fats could not, of course, be considered a strictly controlled group. They were, however, selected on the basis of their deep personal interest and their ability to cooperate in carrying out the therapeutic measures. The data collected on this group demonstrated a wide variation in response of the serum cholesterol levels. Although it is impossible to evaluate the peaks of the curves an impression was obtained that certainly some were related to emotional stress in several of these patients.

Conclusions: In this series of 59 cases the level of serum cholesterol above or below 250 mg., in single or serial determinations, has not reflected the presence or absence of clinical complications of atherosclerosis.

A diet low in saturated and hydrogenated fats in conjunction with the use of corn oil and a preparation of safflower oil containing 80 per cent linoleic acid in doses of 15-30 ml. daily failed to consistently reduce the levels of serum cholesterol in a group of 16 patients who exhibited clinical manifestations of atherosclerosis.

The level of serum cholesterol found at various intervals has been quite variable and erratic in presumably normal and in atherosclerotic men and because of this variability

the level does not appear to be of any value for the prognosis of the development of complications of atherosclerosis.

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BENIGN TUMORS OF THE ESOPHAGUS

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In spite of their rarity, a familiarity with benign tumors of the esophagus is important because of the ability of these tumors to manifest themselves in odd and confusing ways. Failure to consider these tumors could lead a clinician to label wrongly the possessor of this easily treated lesion as psychoneurotic. The radiologist has misdiagnosed this tumor as achalasia and the esophagoscopist has been known to overlook the tumor altogether.

Incidence

Benign tumors of the esophagus are found infrequently both clinically and at necropsy. In 7429 autopsies up to 1943 at the Mayo Clinic, 33 of these lesions were found.¹ At the University of Chicago in 6301 autopsies up to 1950, only 11 were found.² Adams and Hoover³ reviewed the literature up to 1945, finding 94 and adding 3 of their own. Harrington⁴ added 6 in 1949. Myers and Bradshaw⁵ added 3 and found 39 in 1951. The exact number reported is impossible to determine but well over 100 cases have been

recorded. Malignant tumors are ten times more common than the benign lesions.

The leiomyoma is the most frequently encountered benign tumor of the esophagus. This tumor is more common in males and is more likely to be found in the middle or lower esophagus.

Polyps are second in frequency, representing 20 per cent of all benign tumors. These polyps are usually composed of varying amounts of fibrous, vascular, or lipomatous tissue. Other tumors encountered in the esophagus of a benign nature include fibromas, hemangiomas, mucocoeles, neurofibromas, papillomas, adenomas, aberrant thyroid cysts, and myxofibromas.

Benign tumors of the esophagus fall into two groups; the mucosal tumors, which are the polyps and polypoid tumors for the most part, and the intramural tumors which lie within the wall of the esophagus. The common tumor of the latter group is the leiomyoma arising from the muscle layers of the esophageal wall.

Symptomatology

Most reports state that benign tumors do

not cause symptoms, however in the case reports reviewed here slightly more than two-thirds of these reported cases presented with symptoms thought to be due to the tumor. Of Sweet's⁶ series of 47 benign tumors, 43 were symptomatic. On the other hand Rose⁷ reported a series of 49 of which only 6 caused complaints. Chi and Adams,² collected a series of 102 myomas of which only 16 had symptoms. The polyp is the most likely of the benign tumors to cause symptoms. Of the intramural tumors, as would be expected, the large or encircling tumors are more likely to cause symptoms.

Of all the symptoms attributed to benign tumors dysphagia is the most common, but dysphagia as a symptom alone is not often explained on the basis of a benign tumor of the esophagus. Of 11,000 patients studied at the Mayo Clinic for dysphagia only 15 benign tumors were found.¹ Aside from dysphagia, intramural tumors can cause pain not associated with swallowing. Substernal pain may radiate and be confused with cardiac pain.⁶ Digestive symptoms such as epigastric pain, "gas", heartburn, nausea, and vomiting are not uncommon symptoms. Hemorrhage is occasionally encountered and a patient has been known to bleed almost to exsanguination as a result of this lesion.⁶ Bleeding comes about as the result of an ulceration through the mucosa into the tumor.

On occasion an esophageal tumor may present symptoms not referable to the esophagus but rather to the respiratory tract as in the case of Garlick,⁸ whose patient complained of left-sided asthmatic attacks and was found to have a tumor impinging on the left main stem bronchus. Barrett⁹ reported a case in which there were no esophageal symptoms but only cough, dyspnea, and wheezing; the patient had a fibroma measuring $2\frac{1}{2} \times 4\frac{1}{2}$ inches in the esophagus which was not obstructing the esophagus but apparently impinging upon the trachea.

Mucosal tumors may produce much different symptoms because of the long pedicle which often develops. A polyp on a long pedicle may obstruct the cardia and simulate achalasia.^{1,10,11} The esophagus above the obstructed cardia dilates and the polyp itself may

be confused with retained food. Moersch and Harrington¹ reported a patient who complained of repeated sore throat and dysphagia for a three year period, having during that time numerous roentgenologic and esophagoscopic examinations which were reported negative. When seen at the Mayo Clinic the patient showed mediastinal widening and clubbing of the fingers and the diagnosis of achalasia was made. The long pedicle of a polyp may allow regurgitation of the polyp into the mouth or even aspiration of the polyp.^{10,12,13,14} Lorimer¹⁴ reported a case of an elderly man who was seen as an emergency by a local practitioner because of extreme dyspnea resulting from a regurgitated mass. The physician severed the pedicle and removed the mass which measured $5 \times 3 \times 2\frac{1}{2}$ cm. with a pedicle measuring 4 cm. in length. Aspirated polyps can cause dyspnea, cyanosis and even death from asphyxia.^{11,15} In the 40 cases of polyps collected by Totten and Stout,¹⁶ one-third died as a direct or indirect result of the polyp, and in only 3 of these fatal cases was the diagnosis made before death.

Diagnosis

A physician given the history of a fleshy mass regurgitated into the mouth can and should make the diagnosis of a polyp of the esophagus. The burden of proof is then on the radiologist and esophagoscopist to prove the clinician correct. Both can easily fail to offer this proof, as polyps are difficult to demonstrate by either means. Unless they are large polyps are often missed. These masses become obscured in the barium-filled lumen of the esophagus during the barium swallow examination. The esophagoscopist may be unable to recognize the mass of a long polyp within the esophageal lumen but may suspect its presence when the esophagus appears wide on x-ray examination but small by esophagoscopy. This discrepancy is caused by the mass of the polyp itself within the lumen of the esophagus. Polyps develop in older patients at the level of the cricoid cartilage from the loose esophageal folds which form here. The pedicle is probably elongated because of the vigorous peristaltic activity which takes place in this section of the esophagus.¹⁵

Much easier for the radiologist to recognize, but not so for the esophagoscopist, are the intramural tumors. These are often noted incidentally on gastro-intestinal examinations. These show as sharply and smoothly defined defects arising from the wall of the esophagus and projecting into the barium-outlined lumen of the esophagus. The mucosa over these filling defects is intact although at times the folds of the mucosa over the tumor may be widened through stretching by the mass of the tumor. The margins of the defect form a sharp angle with the uninvolved wall of the esophagus above and below. This sharp angle is the most important feature of the benign intramural tumor. Tumors extrinsic to the esophagus, lying adjacent to the esophagus, cause a gentle sweeping indentation which produces a vague obtuse angle with the unimpinged sections of the esophagus above and below the mass. However, this rule is not completely reliable, as a tumor external to the esophagus but firmly adherent to the esophagus can give the impression of an intramural tumor by producing the sharp angle with the adjacent uninvolved portion of the esophagus. And contrariwise an intramural tumor may not always produce this sharp angle. Because the mucosa is intact intramural tumors are often not demonstrable by esophagoscopy as was one of our cases here reported.^{1,17} Biopsy should not be done, as there will be danger of contamination through the interrupted mucosa during the surgical removal.

Occasionally a large benign tumor is first noted on a chest film as a mediastinal mass.

Calcifications demonstrable by x-ray have been reported in a large leiomyoma of the esophagus.⁶

Mucosal lesions are seen as a polypoid mass in the column of contrast media or as a superficial irregularity or ulceration of the mucosa.

Treatment

These tumors should be removed to establish a definite identification and to eliminate the possibility of malignant degeneration. Small tumors should be removed early to avoid growth to a size that could require an esophageal resection. Also early removal may avoid the difficulties encountered with adherence to the wall of the esophagus.⁶ If pos-

sible the tumor should be enucleated without entering the mucosa of the esophagus. The prognosis of intramural tumors treated in this way is good. Of the series of 47 surgically treated intramural tumors collected by Sweet,⁶ 37 obtained good symptomatic relief through surgery. In this series four had no symptoms before surgery. Pedunculated polyps can be removed with a snare applied under esophagoscopic guidance and the pedicle can be severed by surgical diathermy.¹



Case #1. A smoothly defined filling defect is noted in the column of contrast media, demarcated at its superior and inferior margins by a sharp angle with the normal wall. The adenocarcinoma of the esophagus lies several centimeters below this benign lesion.

Case Reports

Case 1. A 50 year old male was found to have had a small nodule in the right middle lobe on a routine chest roentgenogram two years prior to admission. Thoracotomy was advised but refused. The patient remained asymptomatic until seven weeks prior to admission on October 30, 1957 when he complained of a bilateral pleuritic pain over the lower thoracic cage. A chest film was obtained at this time which showed an increase in the size of the nodule. Four weeks before admission the patient complained of dysphagia and a burning epigastric pain relieved by food. On admission a barium swallow showed a ragged infiltrative lesion just above the cardia, with an overhanging edge and obliteration of the mucosal

pattern. Two centimeters above this lesion was a smoothly defined defect in the outline of the esophagus the size of a golf ball. The impression was that two separate lesions were present; a tumor of the lung and a carcinoma of the esophagus. The smoothly defined filling defect in the esophagus above the lesion diagnosed as a carcinoma was thought to represent a mediastinal node involved with carcinoma impinging on the esophagus. The first operation was performed on November 1, 1957. Bronchoscopy and esophagoscopy were both negative. A right thoracotomy was undertaken. The right middle lobe was removed and a frozen section of the nodule proved it to be a bronchial adenoma. The esophagus was next explored and a benign tumor 2.5 cm. in diameter was removed from the wall of the esophagus without entering the mucosa. This proved to be a leiomyoma. The distal lesion of the esophagus was found to represent an adenocarcinoma. The distal esophagus was removed and an esophagogastrostomy was performed. Metastatic nodules were found in the liver and were proven to be bronchial adenoma. Nodes removed from the mediastinum contained metastatic carcinoma.

Case 2. A 39 year old female had had intermittent abdominal pain for twelve years. In addition to the epigastric pain the patient complained of substernal distress, "lump in the throat", sighing respiration and nervousness. At this time the patient was thought to have had a spastic colon, psychoneurosis, and a duodenal ulcer. The patient did fairly well on an ulcer diet until two months prior to admission, January 23,



Case #2. These films show a sharply defined filling defect in the upper esophagus representing the leiomyoma. Notice the sharp angle that is formed with the normal adjacent wall of the esophagus.

1957, when she developed nausea, vomiting, and epigastric pain not relieved by ulcer treatment. Radiographic studies disclosed the presence of cholelithiasis and a smoothly defined filling defect 2.5 cm. in length projecting into the esophagus for a distance of 1 cm. This lesion was located at the level of the suprasternal notch. This was thought to represent a benign tumor, most likely a leiomyoma. When the patient was informed of the finding and questioned further she claimed moderate dysphagia for one month prior to admission and a feeling of food being delayed at the level of the suprasternal notch. On esophagoscopy a smoothly rounded protrusion into the esophagus was demonstrated 19 cm. from the incisors. The mucosa was intact. Because of a nodule palpable in the left lobe of the thyroid, surgery on the esophageal lesion was performed through a collar incision extended through a split sternum to the fifth intercostal space where the incision was carried laterally. A leiomyoma 3 cm. in length was exposed and enucleated through an incision in the wall of the esophagus without entering the mucosa. The post-operative course was uneventful. The patient continued to present complaints attributed to the cholelithiasis.

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CLINICO-PATHOLOGICAL CONFERENCE

POST GRADUATE ASSEMBLY

Greenville, S. C., April 2, 1958

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The patient, J. M. S., age 58, was first observed in my office on April 27, 1955, referred by Dr. D. O. Thompson of Atlanta.

He was a well developed man who complained of a bothersome skin ailment of both legs, which he referred to as a "rash". The malady was quite distinct around the ankles, and had spread in a scattering manner up to the knees. The "rash" appeared as lesions of a reddish-brown slightly elevated character of variable morphology. Some of the spots were very small, almost pin-point in dimensions, while others were as large as a twenty-five cent piece in diameter, and had bordered, elevated edges, which suggested an eruption of an allergic wheal-type character. There was considerable itching associated. My thought at the time was that the lesions were of some unusual mixed variety of skin dermatitis, possibly related to purpura. My impression was based upon the observation that many of the lesions appeared to differ in color intensity, with small central pin-point dark reactive areas in them. Mr. S. stated that once before he had suffered a similar "rash", but it disappeared. This time, however, it was of sufficient intensity for him to seek medical help, as it was quite disturbing.

The dermatitis came upon this patient after a week-end which he had recently spent largely out in the open spaces. He thought perhaps that some bug had bitten him, because the lesions had begun around his ankles, and had itched badly. In about a week from the above dates when he came to me, the condition had spread in a disorderly fashion up to his thighs, and scattered small areas of a similar character appeared on the skin of his arms and chest. After the allergy, or what have we, had become distributed, Mr. S. then developed a low grade fever: 100-101 degrees, had pains to occur in his wrists and finger joints, with slight swelling and stiffness of his ankles and knees.

Mr. S. was a man of very active nature, who was devoted to his job, church and community. He was in the telephone business, had no bad habits, and was most reliable in character. He did not drink whiskey, nor had he ever been exposed to any unusual types of toxic agents. He had taken aspirin for headaches for years, how much unknown, but not thought enough to be intoxicating. His mother was living and while old, was well. His father died in early manhood from tuberculosis.

Repeated interrogation of the patient brought forth an admission that his malady, while apparently acute from the skin viewpoint, was perhaps associated with a background in which for many months he had not felt as well as he usually had, but he was not

sufficiently sick enough to give up and to seek his physician's opinion. So he kept going.

Physical Notes:

The physical examination of Mr. S., other than the appearance of his skin malady, revealed nothing to be out of order in the lungs, sinuses, abdomen, bones or prostate. Roentgenograms were negative. Blood pressure 180/90, blood cultures, serologic tests, agglutinations, L. E. cells, etc., negative. No abnormal lymph nodes found. Spleen not enlarged. Ankles, finger joints were slightly painful when pressed upon or used very much, but very little swelling was observed. Orientation, good. He weighed about 170 pounds.

I might at this point add that the patient had long complained of a "one sided headache", temporal region, left, which we thought to be of a migrainous type, dismissing it as such.

The skin "rash", erythema, allergy, purpura, or embolic phenomena on the skin areas of the body, whatever they were, gradually faded away after bed rest, leaving barely perceptible spots. He was symptomatically treated with cortisone, fever reducers, penicillin and streptomycin. He appeared to improve, but completely lost all appetite, suffered nausea, became very disturbed, nervous and could not sleep. He apparently was never able to pick up steam and started down hill, from whence he could not return.

Laboratory Notes:

First seen April 27, 1955—RBC, 5,010,000; WBC 11,350; Hgb. 102. Platelets 175,000; index 1. bleed-time 5 min.; Coag. time 7½ min.; Scg. 56; Lymphs 36; Monos. 6; Eos. 2.

Next April 29—WBC 13-14,000; Segs. 70; Lymphs 22; Eos. 2.; Monos. 6. Platelets 70-100,000. Coag. tube 20 min.; retrac. 2 hrs. Kahn negative. Sed. rate, Cutler 12 mm.

April 30—WBC 8,550-9,300; Segs. 64; Lymphs. 32; Monos. 2; Eos. 2. Clot tube 20 min. L. E. cells not found. Blood cultures aerobic and anerobic, one week later-negative. Sed. rate 19 mm.

May 5—WBC 9,750; RBC 4,870,000; Hgb. 104; Platelets 195-220,000; Clot slide 6; Tube 17; Sed. rate 21 mm.

May 11—RBC 4,550,000; Hgb. 90; WBC 10,300; Platelets 150,000; Seg. 78; Lymphs 16; Monos. 4; Eosin. 2; Clot 22 and poorly formed 28 min. tube; Sed. rate 19 mm.

May 19—RBC 4,650,000; Hgb. 100; WBC 20,000; Platelets 270,000; Scg. 70; Lymphs 24; Eos 2; Clot slide 6; Tube 12; Sed. rate 22. At this date seemed improved.

June 6—Home: RBC 4,440,000; Hgb. 94; WBC 14,050; Platelets 200,000; Seg. 72; Lymphs 18; Monos 4; Eos 6; Clot time 12-15 min. Agglutinins for fevers all negative. Sed. rate 27 mm.

June 21—Home: RBC 4,750,000; Hgb. 94; WBC 14,750; Platelets 190,000; Seg. 80; Lymphs 8; Monos 8; Eos 4; Sed. rate 26 mm. Urinalysis-Albumin ++; RBC +++++, occas. cast.

July 8—Home: RBC 4,350,000; Hgb. 88; WBC 16,700; Platelets 200,000; Seg. 78; Lymphs 10; Juvs 3; Monos 4; Eos 4; Myelo 2; Hemat. 39; Sed. rate 20-25; L. E. cells not found. Blood group O, Rh negative. Feels better. Purpura? seems lighter or improved.

July 14—Complete urine studies AM, PM; Albumin ++ fairly numerous RBC-casts noted; Hyal. and epith. Sp. Gr. 1010.

July 26—Urine positive albumin +++++; RBC numerous: casts noted. Casts quite conspicuous.

July 28—RBC 4,210,000; Hgb. 84; WBC 30,400; Platelets appear normal in number on smears; Seg. 90; Lymphs 10; Sed. rate 30 mm.; Dextrose 115; N.P.N. 60/65; Sed. rate 30 mm.

General Discussion:

Mr. S. was examined and treated for an unexplained hypochromic anemia in 1947. He responded. B. P. at that time 120/80.

In 1948 he suffered an attack of "cold" and sore throat.

In 1950 he had what his physician thought was a viral infection, was ill one week with "cold" and sore throat.

In 1953 had sciatica. Recovered. Later in December 1953 had another "cold" and was given Gantrisin for 5 days.

1955, April B. P. 130/80. Had what dermatologist diagnosed as purpura simplex. Recovered. Roentgenogram of the chest at that date, negative. Urinalysis, negative.

At the time of his last illness, which we have tried to describe in some detail for you, the patient after his failure to respond, was seen by consultants and in addition his case history was reviewed by the hospital staff. The discussions here were lively but brought no unanimous opinion as to the diagnosis: Several maladies were mentioned, such as tuberculosis, septicemia, purpura hemorrhagica, lupus erythematosus, contact dermatitis, urticaria, insect bite, Hodgkins disease, leukemia, rheumatic fever with purpuric syndrome, arthritis, thromboembolism, cirrhosis of the liver, or possibly some form of an intoxication which he had absorbed and evidently had severely damaged his circulatory system, or a deficiency syndrome, unclassified. The bone marrow was unrevealing.

I should also like to emphasize the many repeat blood tests, etc. and numerous other laboratory examinations which were done on this patient. Of those several stand out as important, such as the *constant rapid sedimentation rate* (Cutler), the gradual increase in *leucocyte count*, and an increase in seg-

menters with an *erratic eosinophilic reaction* in low numbers. His urine was of considerable interest in that *albumin while at first* was little, increased in quantity, and casts were always found, hyaline, granular and mixed types, with a gradual increase in *erythrocytes*. From the very first day *erythrocytes* could be *easily found* in the urine.

Terminal Notes:

When we had exhausted our therapy and hope began to fade and the patient apparently sensed his condition, he was put in the hospital so that he could have oxygen and intravenous aid as become necessary. But he went on from a badly debilitated condition to a worse one and approached semi-consciousness and unconsciousness. The NPN and creatinin rose upward to dangerous levels. His urinary output shut off slowly and uremia came along. There were ascites and pulmonary congestion. A roentgenogram a few days prior to exitus had this to show:

"Very extensive splotchy density involving 3/4 mesial lung fields, which tend to be nodular, and vary in size from a few mm. to a few cm. in diameter, and have fuzzy margins. Extreme lung peripheral areas not involved."

Impression: Severe congestion with edema. *Not thought to be malignant.*

Mr. S. Died July 30, 1955.

Discussion by Dr. Walter Akenhead, New Orleans—

To give a summary of the summary, it seems to me that this is a 58-year old man whose illness lasted about 2-1/2 months roughly, that is after he came under observation, but we are led to believe that he had been sick some little time before. He felt poorly at least. Now, his disease seemed to be characterized by a rash and the description of this rash does not recall any particular disease. He had some sort of rash that varied somewhere between urticaria and purpura. In addition to a rash, he had fever, he had some arthralgia. It is not quite clear whether he had very much swelling. The patient said he had a little swelling of the joints, but the examiner did not find any. In any event, this man with these findings, and that's about all, went on to develop rapidly progressing renal failure, evidenced by nitrogen retention, presence of albumin and blood in the urine and, eventually, I presume, anuria. His parting x-ray, after he was in the hospital, was said to show a nodular type of density that was not thought to be malignant, so we can ask ourselves the question, "what was the density of the lung due to?". It seems to me that we have a couple of choices. Either this man had congestive heart failure with that shadow in the lung, or since it is described as a nodular type of density, and we are led to believe that he was uremic, one can think he had a uremic pneumonitis. But that is beside the point. That is the termination of this thing, so we go back to see . . .

There are some laboratory findings that I think of at the moment—the increasing leukocytosis, and this variation in the platelet count excites me; you've got

the whole raft of platelet counts and one of them is a little off and there is some allusion to the fact that there is some clot disturbance. Maybe Dr. Gendel can give out on that. I believe in approaching C. P. C.'s as an educational exercise and in most instances I think diagnosis is a positive phenomena and the differential diagnosis, except for educational purposes, is a form of mental masturbation, because usually one takes a whole host of things and goes down the line and rules out everything. When you get through, "there ain't nothing left". But since this a C. P. C. and is an educational exercise, and not a contest, although at times I wonder, I should mention some things that come to mind. The fact that this rash began after the man was out in the woods, would make one wonder if he didn't have some sort of rickettsial disorder, but I think the passage of time sort of takes care of that and that this man probably did not have rickettsial disease. I would like to say that the people who saw him did not think he had tuberculosis. I see no reason to think he did either. Septicemia—I presume he had some blood cultures and probably many blood cultures and I presume they were all negative, so septicemia I think we could rule out. Also, although it is extremely dangerous, to rule out subacute bacterial endocarditis as mentioned in our discussion yesterday. There is no reason actually to believe that the man had it, except that he had some purpuric spots and he had fever of some duration, and eventually went into heart failure. Usually people with bacterial endocarditis, when they die of renal failure it's sometime in the future. It is not an uncommon thing to cure somebody with bacterial endocarditis, only to have them die with renal failure some months afterward. I am willing to rule it out, at least temporarily, because of the absence of murmur, no enlargement of the spleen, etc. Purpura hemorrhagica, that to me is a description, unless they mean the meningococcal type of disease, and he lived too long for that. One can have a chronic recurrent type of meningococcal infection which gives you joint disease and gives you purpura and fever, and may have nodular areas beneath the skin that you can feel and they are tender, but I never heard of one of them being recurrent over a period of three months. I have seen them go for a couple of months but eventually they either get well or develop meningitis. Lupus erythematosus is a little exciting in the diagnostic possibility, but in the absence of a skin test or at least the LE test being negative and the fact that this patient had a leukocytosis, is against it. However, it does not rule it out. Contact dermatitis—contact with what? and it usually does not kill people. Urticaria, insect bite, I don't know which. In Hodgkin's disease, you would expect a lymph node somewhere, unless it were retroperitoneal and that is possible but I do not know how we can diagnosis it or even suspect it, other than mentioning it. Leukemia—I'll leave to Dr. Gendel. Rheumatic fever with purpuric syndrome is possible, but again we have no

reason to think that it is. Arthritis, thromboembolism, cirrhosis, etc. Well, I'll get around to saying what I think this patient had because I think one ought to make at least a good stab at it whether it is right or wrong. I think the answer to this whole problem is a purpuric thing and I'm going to take it for granted that this was purpuric, and that eventually it ended with renal disease and he had fever all along. I think that this man had some sort of vasculitis. This migraine history is inviting—he might have had a vascular difficulty there. So some sort of vasculitis on the order of a periarteritis nodosa or a hypersensitivity angitis, I think we could consider, but since there was one platelet count that was down and since it's also a good C. P. C. diagnosis and a "h . . . of a wild one", I'm going to take a stab that this might be Moszkowicz's syndrome or disseminated platelet thrombosis. It acts like a collagen disease with vascular complications. Of course, I could think that this was a collagen disorder, but that doesn't say very much because the connective tissue is the largest organ in the body and comprises a great part of it. I might add that I don't feel at all secure in this diagnosis.

Dr. Norris: I want to thank you, Dr. Akenhead, for your discussion. We'll now jump on one of my old Atlanta heavyweights here and see what he has to say. Dr. Gendel.

Discussion by Dr. B. R. Gendel, Atlanta—

I wonder what Dr. Norris meant when he said "heavyweights".

If Dr. Akenhead feels insecure, I certainly must here as well. I'll try not to overlap too much of this discussion because he has covered many of the features here. I'll try to comment on a few things that I jotted down as we hurriedly tried to get through the protocol and collect our thoughts. Since I was asked to comment on this clotting time that was borderline, slightly increased, and at one time there was an impairment in clot retraction, I must say that I don't know how to tie all this in together. An increase in clotting time is due to one of three causes. First—there is a decrease in the positive factors which promote coagulation. Classically, this would be a decrease in AHG or hemophilia. Secondly, the clotting time may be prolonged because there is an anticoagulant. Thirdly, the clotting time may appear prolonged because there is a fibrinolysin present, and if the fibrinolysin is so active that simultaneously with the formation of the clot, or in the next shake of the tube the clot is dissolved, you may go on with blood maybe completely incoagulable. So the finding of a prolonged clotting time brings up these three possibilities. I jotted these down and put down what they might mean. Well, I have decreased clotting factor—and I don't know which of the host of things that we discussed yesterday this might be and I have a question mark. The anticoagulant—if you recall, there was an antithromboplastin which appeared in ten percent of a series of patients with collagen disease, and some-

times in polyarteritis nodosa. Thirdly, there is the fibrinolytic activity on this patient. As we mentioned yesterday, patients with cancer may have fibrinolysis, particularly prostatic cancer. We also mentioned that patients with prostatic cancer who had fibrinolysis all have metastatic disease to bone. Since the chest x-ray was reported negatively originally and in some of these patients the radiologist overlooks this . . . When you look back later you may find something there that suggests metastatic disease to bone. This brings us down to what did I jot down here. I have down here as my best possibility collagen disease, polyarteritis nodosa. This would explain in this patient one of the reasons for the rash. If you do a biopsy of it, this usually is some sort of vasculitis. We mentioned yesterday the similarity of the Moszkowicz's syndrome pathologically to that of polyarteritis nodosa. This is a vasculitis too. Some years ago Dr. Allen in New York commented on insect bites that looked like vasculitis on histologic study. Some patients with collagen disease, particularly the dermatomyositis variety, which this doesn't suggest but these things overlap so much that we have to be cautious—patients with dermatomyositis frequently have coexisting cancer, so we have to keep this in the background of our information. He had fever. He had joint pain. He had kidney involvement. He had slight variable eosinophilia. He had lung lesions, and some of these patients with polyarteritis nodosa will have lung lesions, which may be migratory. He had sciatica and in polyarteritis nodosa, classically you may get a mono-neuritis. He had Gantrisin. Dr. Norris may have sucked me in on this one, but the association that he makes of allergy in animals, that polyarteritis is brought up by the Gantrisin. This seems to me to be the best possibility. There are a few other things that I thought about as they went through the protocol. One was when he started having these pains in his wrists and finger joints, stiffness, could this man have a carcinoma of the lungs with a collagen disease coexisting, dermatomyositis, cancer, and could this be hypertrophic osteoarthropathy? I never could satisfactorily answer this. It is interesting that terminally he had lung lesions. I am sure that all of us in our practice have seen patients who have had no evidence of lung cancer on x-ray and no suspicion (like Senator Taft) until autopsy when you find a little nubbin of the lesion in the bronchial tree with extensive metastases. So this is one thing that came to mind. The other thing that Dr. Akenhead asked me to comment on was the matter of leukemia versus leukemoid reaction. I would find it difficult to accept this as leukemia. The patient develops a slight anemia during the course and a progressive rise in white count, a progressive rise in polys. On one occasion 2 myelocytes found. The problem of differentiating a leukemia from a leukemoid reaction is sometimes difficult, but here, I believe, this is leukemoid reaction and not leukemia. It is noteworthy, too, that patients with bronchogenic carcinoma are occasion-

ally seen with marked hyperleukocytosis, such as this patient had, and that is another thing that came up with bronchogenic carcinoma possibility. There is one thing that seems to have some promise in trying to differentiate the difficult situation when you are distinguishing a leukemia from a leukemoid reaction and that is the use of histochemical staining with alkaline phosphatase. Leukemic cells do not pick up alkaline phosphatase. Leukemoid reactions—the cells behave normally and do pick up alkaline phosphatase. The first thing I jotted down as we came along here were these purpuric lesions on the legs, and since we heard nothing this morning about xanthomatosis xanthoma diabeticorum came up, and this patient has a blood sugar of 115.

(I don't know whether this is fasting, post-prandial, Folin-Wu or Somogyi, so I don't know how to interpret this. (From the audience—"normal") Then we can forget it. But it just goes to show you the problems we have in interpreting laboratory data from time to time. A fasting Somogyi, this would be real high.)

Then, there are two other things that came up. In any patient who has a chronic dermatitis that itches and lasts and the patient doesn't get better and the rash recurs, one has to think of mycosis fungoides. I don't know how this ties in here and I won't discuss mycosis fungoides any further, because I have a sort of a stab in the dark—you see, once in a while, I have been stuck on a C. P. C. once before—once you're stuck you don't forget; and that is these lesions turned out in this last patient to be Kaposi's hemorrhagic sarcoma. This patient had Kaposi's hemorrhagic sarcoma, and this very frequently coincides with two other diseases—one—diabetes (we scratched that, though) and the other a lymphoma, a lymphosarcoma. So these come back again. As far as Moszkowicz's disease which Dr. Akenhead brought up, it's a good stab. I've seen my share of these patients, and I don't feel that this is it because the patients usually have a significant hemolytic anemia. If you recall yesterday, we discussed this disease, calling it thrombotic thrombocytopenic purpura, and this disease had a triad of (1) thrombopenia (2) hemolytic anemia and (3) neurologic changes, which may be transient or, if the patient progresses rapidly downhill, are permanent. I would be surprised if we found this. My guess is (1) this is going to be one of the collagen diseases and I would gather polyarteritis nodosa. I would not be too surprised if we wound up with one of these other rarities we stuck in like you do on C. P. C.'s.

Dr. Norris: Thank you, doctor. We appreciate your discussion. Dr. Frazier, you certainly made a wonderful talk on asthma this morning. Would you like to say a word or two? I believe you're looking pretty wise.

Discussion by Dr. Claude Frazier, Asheville—

In a way, this comes under the broad field of allergy—collagen disease. I just wanted to say that I

have seen one case where the patient had been taking a sulfa drug, with no known lesion of any kind except a sore throat, and had been followed in a clinic with no signs of rheumatic fever found; he had Aschoff bodies in his heart and he developed joint symptoms, hematuria and everything else, after taking sulfa. You can get a similar thing with drug allergy. The only thing, there is just a little longer period between taking sulfa and this developing. You can get it, of course as mentioned in the work at Johns Hopkins—taking a guinea pig, streptococcus was available in making it under the microscope look like acute nephritis, same appearing with heart tissue, looking just like rheumatic fever. I think from reading it over that it is a vasculitis. It seems first he had those blood vessels being occluded letting through a little bit of edema fluid and later on blood cells and then casts. So, I would say one of the vasculitis diseases.

Dr. Norris: Anyone else like to come up? Answering questions from the audience — Fingers? No sir, he didn't have any x-ray made of his fingers. No, he didn't have a meningitis. I only mentioned that because I am highly impressed with a lot of allergic conditions that we see, whose name I won't refer to right now, may come about by some allergen that the patient had been taking. He took Gantrisin you know one time, and then while his physician said that he was not a taker of aspirin, after talking with this man quite a bit, I became quite convinced that he had been taking aspirin in rather good quantities, possibly for a long time. He had a migraine headache, you see, and at that time I was thinking about the possibility of some collagen disturbance. He had an allergen which was precipitating the thing and that's the reason why I emphasize the migraine headache. The migraine headache alone is not important to me, but it was important to me because the person who has migraine headache, as we all know, real migraine headache, has got to have some relief. They will not only take aspirin, or anything, for long periods of time in enormous quantities unless they are warned—sometimes you just have to take it away from them. Does that answer your question? Sarcoid? No, we never suspected the possibility. Well, I think possibly one time in discussing the case, sarcoid was considered, but just considered and that was all.

Now, this is a summary that the pathologist informs me that he found on autopsy. He found, of course, he had a rather marked pulmonary edema, an enlarged heart, congestive heart failure, ascites, and chest effusion. There was chronic nephritis of a rather marked degree, but the kidneys did not appear to be reduced in size. My discussors here did emphasize something that I thought maybe they were going to

get off on, but they just took it for granted. The essential findings were, of course, observed in the histologic section, which showed a periarteritis involving the kidneys, spleen, liver, pancreas, etc., with small vascular aneurysms. A conspicuous aneurysm was found in one renal artery. The patient also, in his x-ray picture had an interstitial terminal pneumonitis. Therefore, we felt periarteritis nodosa to be the malady from which Mr. S. suffered, accompanied with purpura, hemorrhagic and severe chronic nephritis, finally terminating in congestive heart failure and uremia, complicated with the terminal pneumonitis. I may also add, with all modesty and humility, that periarteritis nodosa was the diagnosis made before Mr. S. died. Someone justifiably asked how we arrived at that diagnosis, and I think that we arrived at that diagnosis largely on the basis of the clinical and laboratory findings that have been emphasized by my two heavyweights here. Largely, the thought occurred to us that the cause of the bizarre symptoms which the patient exhibited, along with the purpura, everything possible otherwise being eliminated, and nephritis came into the picture as a gradual disablement. It appeared that there was something vague afflicting this man. Something that was slowly destroying him, and yet we could not definitely put our finger on it. I think that is one of the most important points that I will leave with you today, if you have learned anything from this lesson. Since I am an old teacher and not a very good one, I want to reiterate that feeling. It appeared that there was something vague afflicting this man, slowly destroying him, and yet we could not place our finger on it. With so many other diseases eliminated, naturally we narrowed down and thought of periarteritis. Now periarteritis, known also as Kussmaul-Maier disease and as a polyarteritis, and necrotizing arteritis, is a disease of middle life, more common in males than females. It is a collagen disease. It may be allergic and is commonly manifested by fever, urticaria, edema, erythema with leukocytosis and mild erratic type of eosinophilia, followed often by fibrinoid pneumonia, uremia, joint pains and tenderness. At times small skin nodules may be found and the patient may suffer from neuritis, chronic anemia, and a vague trend of other abnormalities. It is uniformly fatal. However, if detected early enough, with the present knowledge of new therapeutic aids, and the allergen be removed, and I feel very strongly about this, cortisone or some of these other hormones may control it. Thus, there is considerable hope for the future in the management of what has otherwise been known and recognized as a fatal condition.



LIMITATIONS TO THE CHEMOTHERAPY OF LYMPHOCYTIC LEUKEMIA

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A recent study on the management of 2910 cases of lymphocytic leukemia with chemicals¹⁴ presented the opportunity to explore some of the limitations to this form of therapy. The most serious limitation to the evaluation of chemotherapy in leukemia is the absence of objective standards. The hundreds of clinical reports are published from medical centers all over the world. Some are supported with detailed clinical and laboratory data on objective evidence of improvement, while others record only the physicians' impressions of the therapy, or the patients' subjective response. The terms, "good remission", "fair remission", "poor response", etc. carry different meanings with different investigators.

Folic Acid Antagonists. Lymphocytic leukemia is less responsive to folic acid antagonists than any of the frequently employed chemotherapeutic agents. Of the 378 cases described in 51 reports 24 are found in articles failing to record the number of remissions. The 197 remissions reported give a 55% response to FAA therapy, but not more than one-third could be classed as good remissions. Smith¹⁶ described the response of his patients as showing improvement rather than remissions, and Maness¹⁰ concluded the results with FAA do not justify their use. A number of investigators describe serious toxic effects. Ruggeri¹³ reports one patient dying of hemorrhage within one month after initiation of the therapy and Soto¹⁷ stated that aminopterin hastened the end in two out of five patients. Wintrobe²¹ reported FAA therapy was contraindicated in lymphatic leukemia. Only 27 cases of chronic lymphatic leukemia have been treated with folic acid antagonists in articles covered in this survey, and the response was not promising.

Radiophosphorus. Thirty-three published reports describe the management of 726 cases of

lymphocytic leukemia with P³². However, 250 of these occur in articles failing to give data on the number of remissions. The 476 remaining cases showed 278 remissions for a 58% response. Half of these remissions could be classed as good in acute lymphatic leukemia, while none of the 8 chronic responded. Barnes¹ described an increase in the number of papules with P³².

6-Mercaptopurine. 6-MP is a more promising agent for acute lymphocytic leukemia. None of 8 cases of the chronic form showed any effect, but 102 of the acute had remissions, and half these could be classed as good in the 25 reports. Seventeen of the 157 cases were in reports not giving data on remissions, so that the remission rate is 73%. Gold⁵ recently described three cases of hyperuricemia developing during 6-MP therapy. Wintrobe²¹ listed this agent as contraindicated in lymphatic leukemia therapy.

ACTH/Cortisone. One-third of the 305 acute cases of lymphocytic leukemia and one-third of the 155 chronic cases responded well to ACTH/cortisone therapy in 100 publications surveyed. A number of authors, however, comment on the brief and inconsistent results.^{2,3,6,11,20} Stefanini¹⁸ reported prednisone stopped the bleeding but that there was no improvement in the patient's condition. Saric¹⁵ reported large rectovaginal and rectoperineal perforations during cortisone therapy. Several noted lessened resistance to tuberculosis on ACTH therapy. Videbaek¹⁹ noted one patient with chronic lymphocytic leukemia grew worse on ACTH therapy.

Triethylene Melamine. TEM, like ACTH/cortisone therapy, resulted in 68% remissions, after making corrections for the reports which failed to give both the number of cases treated and the number responding (490 cases were treated with TEM but 19 of these were in articles giving no data on remissions; with 321 remissions in 471 cases, the rate was 68%).

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Only 38 acute cases were treated in the 80 articles surveyed, and only 6 of these could be classed as good remissions. Luhrs⁹ described an epithelial carcinoma which developed simultaneously with TEM management of leukemia, and Ferrari⁴ warned of bone damage with the drug.

Nitrogen Mustards. The total of 564 cases of lymphocytic leukemia treated with N-mustards in 90 reports is second only to P³² in the extent of the clinical trials made, but 123 of these appear in articles giving no data on the remissions. With a record of 321 remissions the rate becomes 72%. Only 14 of the 564 cases were acute, and N-mustards had little or no effect on these. One-half of the chronic remissions were classed as good. Lamy⁷ reported severe purpura on CB 1348 therapy.

Urethan. None of 11 acute lymphatic leukemia patients had good remissions on urethan, and only 20 of 109 chronic cases were complete remissions. Of the 125 acute and chronic cases 24 were in papers failing to give the number responding, leaving 101 to give a 76% rate. Wintrobe²⁰ reported no response in urethan therapy.

Miscellaneous Agents. Some 50 miscellaneous chemicals have been given clinical trials in lymphatic leukemia. Colchicines have accounted for 15 of these studies, but the remission rate of 30% is not promising, and Leonard⁸ noted that colcemid aggravated the condition. Phosphoramides show a remission rate of 79%, but the total of 29 cases is too limited for statistical significance. The overall remission rate of 61% for 299 cases indicates that some of the agents have potential value in lymphocytic leukemia.

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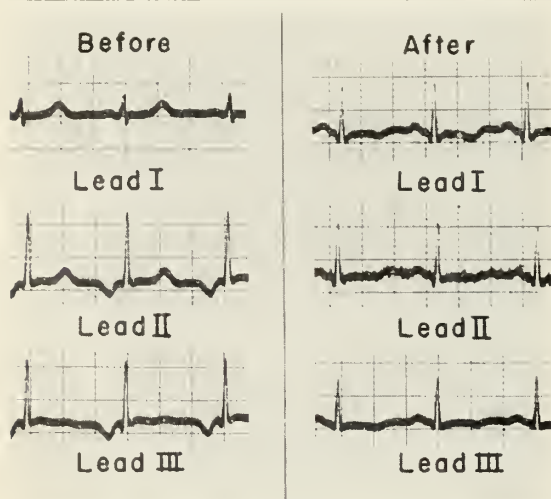
ELECTROCARDIOGRAM OF THE MONTH

Nodal Rhythm

DALE GROOM, M. D.
Department of Medicine

Case Record—A young mother concerned over a problem of considerable emotional impact complained of palpitation and other symptoms of an obviously functional nature. Aside from the unusual electrocardiogram shown on the left, no abnormalities could be found on a complete cardiac examination.

Several days later a repeat tracing was made after carefully checking the placement of the limb electrodes and the results were identical. The patient was then given moderate doses of quinidine for one day, following which the electrocardiogram on the right was recorded.



Electrocardiogram—Both before and after quinidine administration the rate is approximately 95 per minute with a regular rhythm. The most notable feature is the inversion of P waves in standard leads II and III. (The P waves were also inverted in aVf and upright in aVr.) After the medication polarity of these P waves is reversed to normal though the P-R interval remains about the same, 0.16 sec.

The ventricular complexes also show some changes following quinidine, more than can be attributed to an alteration in the electrical axis. Particularly in lead I the configuration of the QRS is different—it appears wider, and the T waves have become flattened or inverted in all three standard leads.

Discussion—The innate rhythmicity of the heart is illustrated by its remarkable faculty of maintaining effective contractions in the absence of rhythmic stimuli from its normal pacemaker. Depression of the sino-atrial node by increased vagal tone or by ischemic or inflammatory damage may so retard impulse formation that a lower center takes over the pacemaking function of the heart. These so-called "escape rhythms" arise in some other area of the atria, in the atrioventricular node, the bundles of His, or the ventricular musculature itself, and their rates tend to be slower in that order of succession. Such ectopic rhythms are distinguished from the tachycardias which are thought to represent actual enhancement of activity of the ectopic focus.

Site of the pacemaker in this case is probably in or near the A-V node. The control tracing is typical of what has been described as "coronary sinus rhythm" in which the impulses arise above that portion of the node which gives rise to the normal delay in A-V conduction. The P waves therefore precede their QRS complexes and their reversed polarity is due to a reversal in direction of atrial conduction which is upward, toward the right arm and away from the left leg electrode. The same considerations as to retrograde atrial conduction and ventricular response discussed under nodal tachycardia¹ apply in nodal rhythm.

Characteristically the ventricular complexes are not altered by a shift of the pacemaker from the S-A to the A-V node. Perhaps the most likely explanation for the QRS and T wave changes seen in this case is aberrant ventricular conduction, the ventricles receiving their stimuli less synchronously or along slightly different pathways from the node. There is also the possibility that the quinidine may have altered conduction at the ventricular level. Two other atypical features in this case are the similarity of rates and of P-R intervals before and after treatments: as a rule, the rate of a nodal rhythm is on the order of 40 to 80 and the P-R interval is somewhat shorter than that of the normal sinus rhythm.

The functional nature of the electrocardiographic abnormalities in this case is evident from the lack of real symptoms or signs of heart disease, the ready reversibility of the ectopic rhythm, and subsequent observation of the patient for more than a year during which she showed no evidence of cardiac impairment. Isolated nodal beats and transient nodal rhythms can be produced experimentally in some subjects by eyeball or carotid sinus pressure, as well as by digitalis toxicity, and in this patient it was probably a vagal manifestation of anxiety. Whether or not the quinidine caused reversion of the rhythm to normal is uncertain.

Reversion has been attributed in some cases to vigorous physical exercise or administration of atropine or quinidine, but doubtless in many instances it occurs spontaneously—perhaps with simple reassurance. A diagnosis of myocardial pathology from the initial electrocardiogram of this young lady might have in-

creased her anxiety and added the complication of iatrogenic heart disease.

REFERENCE

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THE SOCIETY FOR THE RELIEF OF THE FAMILIES OF DECEASED AND DISABLED INDIGENT MEMBERS OF THE MEDICAL PROFESSION OF THE STATE OF SOUTH CAROLINA

WILLIAM ATMAR SMITH, M. D.
Charleston, S. C.

This Society with its long but appropriate and comprehensive name has existed for more than a century, but there are probably only a comparatively few doctors throughout the State who have known about it. Besides being ancient it is probably the oldest Society of its kind in the country. It is singularly rare in its conception and operation and in this respect being perhaps unique—in the true sense of that word—there is no other like it in the world.

Although this charitable organization of South Carolina is an unusual one it is known that there are similar so-called "Benevolent" Societies in this country and in the British Isles. There is one in London, said to be quite large and wealthy, which is said to be conducted somewhat on the lines of Group Insurance. There is one in Ireland which assesses each member to raise funds for doctors families who are in great financial need. There is one in New York State, one in Massachusetts, and one in New Jersey, and in Los Angeles there is a very large Society devoted to aiding indigent physicians and their families. This last organization also conducts a "Home" to give temporary assistance to medical families.

The Society for the Relief of the Families of Deceased and Disabled Indigent Members of the Medical Profession of the State of South Carolina originated in Charleston, and for purposes of brevity has been known to its membership as the "Widows and Orphans Society." The purpose, as set forth in the Act of Incorporation, is as follows: "That the principal end of the said corporation shall be, to succor and maintain, and relieve the families of deceased and disabled indigent members of the Medical Profession of the State of South Carolina, members thereof, in such manner, and according to such rules and regulations as they may see fit to establish."

Dr. Archibald J. Buist, in his history of the Society which he read at its Centennial Meeting in 1948, was unable to obtain from available records the circumstances which led to the birth of the Society nor was he able to ascertain the names of its founders. It is concluded from such meager data available that during the siege of Charleston in the course of the war for Southern Independence that the charter, the

minute book and most of the historical records were "destroyed in flames by Sherman's army in the course of the infamous march through the State." The Treasurer's books and papers were by some miracle held in Charleston and thus saved. These records proved the most valuable source for the compilation of Dr. Buist's excellent history.

A perusal of this history and reviewing the Constitution and By-laws of this ancient benevolent organization would establish the justice of the attribute of being unique.

Although the founding fathers are not definitely known, their wisdom and business insight excites one's imagination and as they were all undoubtedly quite poor their generosity and kindness wins admiration.

Here are a few quotes from The Constitution and By-laws:

"Any person of good moral character may be admitted a member of this Society."

"The Society's aid is designed solely for distressed families of deceased or disabled members of the Medical Profession in the State of South Carolina."

"The names of benefactors of this Society shall be honorably mentioned in the journals of the same."

"No monies belonging to the Society shall be loaned to any member thereof."

"The members of the Society shall annually assemble and dine or sup together in the City of Charleston on the second Wednesday in January."

"Not less than one-fourth of the annual income shall be placed in the permanent fund for investment."

The Society is managed by a standing committee composed of the officers of the Society and eight other members all of whom are elected annually.

Its particular function is to safeguard the funds of the Society and to arrange for distribution of its small bounty to those medical families who are in need of financial assistance. No one in need of assistance has to apply for it. A sub-committee, known as the "Committee on Bounty," makes necessary investigations and makes recommendations to the Standing Committee.

The chief source of revenue is from the dues of the active members. Very few donations have been re-

ceived. The annual dues have always been small and as a result the principal sum held for investment has necessarily been slow in its growth. Due to careful management of able treasurers the treasury now boasts about \$25,000. Returns from this and from the annual membership dues made it possible to distribute each year \$500 to \$600 to those families of unfortunate colleagues. A much bigger endowment is imperative if this ancient Society is to properly fulfill its mission.

At its last meeting, upon recommendation of the Standing Committee, the Society decided to make its aims and purpose more widely known to the profession of the State with a view of affording such physicians an opportunity to join, making it a statewide Society in fact as well as in name.

It is quite possible that the founding Fathers, in addition to their more serious and charitable motives, had in mind making its only meeting a pleasurable one or else they felt that the social aspect was necessary to maintain the interest of the members. However that may be the by-laws require that the members shall "sup or dine" together on the second Wednesday in January each year.

The wisdom of the social aspect has made these annual gatherings a "medico-social" event in Charleston. There is usually a large turn out of doctors and lay members. A large number dress for the occasion at the urge of the President but evening dress is not mandatory. Post-prandial entertainment is by talent from the membership and is arranged by a program committee. Group singing is the most popular part of the program.

At its annual meeting new members are initiated. At one time in its history it is stated that this initiation program became somewhat ribald and rough on the candidate. In recent years, however, a more dignified procedure is carried out though still not without a touch of gaiety. The candidates are brought before the President who extoles the virtues and aims of the Society, requests the candidates to repeat its long name, requires them to sing "A Pie Sat on a Pear Tree," after which they drink a toast to the health of the Widows and Orphans and make a fervent hope that none of those they leave behind will need the Society's bounty.

During the recent past a rather interesting event occurred when ambiguity was found in the Act of Incorporation passed by the Legislature in 1849.

"The ambiguity, which halted planning on an aid project last year, appeared in Section 11 of the society's incorporation acts, which read:

"... the principal end of the said corporation shall be, to succor and maintain, and relieve the families of deceased and disabled indigent members of the Medical Profession of the State of South Carolina, members thereof, in such a manner . . ."

Some members of the relief society contended that the words "members thereof" meant members of the Society. Others interpreted the "members thereof" as members of the medical profession. The president asked four judge friends for informal rulings. The judges split, 2 to 2 on their interpretations. The president then asked eight lawyers for their unofficial opinions. This time the score was 4 to 4. Shortly thereafter a state senator introduced the bill amending Section 11 to make the incorporation 'acts to read,' "... members of the medical profession of the State of South Carolina. . ."

This change, along with the appropriate changes in the by-laws now enlarges the area of service of this ancient benevolent organization.

The Society now has a membership of 162 and about 15 of them are interested laymen. No serious attempt has been made to recruit lay members. Many of the medical members feel that this would be shifting some of the responsibility. However there are no restrictions in the by-laws.

The medical profession of the State will be sent application forms should any desire to participate. Efforts, too, are being proposed to increase the investment fund by other means than membership dues. None of the plans has matured as yet.

With its meager funds the Society has been able to give only token help to those beneficiaries in need. Throughout the past century this token help has been gratefully received and added to the comfort of many worthy people. Should its assets be augmented by increase in membership and by other plans, greater usefulness and a more adequate fulfilment of its principal end—to succor and maintain and relieve the Families of Deceased and Disabled Indigent members of the Medical Profession of the State of South Carolina.

Dr. Buist closed his 1948 resume of the history of the Society with this thought: "... to my knowledge and belief it is one of the few organizations an individual can join with the fervent hope that not one cent of any money contributed by him will ever have to be made available to any of those near and dear to him, and that the sole benefit from his membership will be derived from the camaraderie of the annual banquet."



CANCER PROGRESS—TRUTH OR FALLACY

FRANK L. GEIGER, M. D.*
Columbia, S. C.

The State-Aid Cancer Clinics maintain cancer registries which record every cancer patient, private and public, in-patient and out-patient, upon whom the diagnosis of cancer is established. According to these registries, 2,515 new cancer cases were

55%, negroes 31%) and in the private patients 61% (whites 64%, negroes 37%) had early cancer.

Listed below by sex are the 10 most frequent types of new cancer cases diagnosed and treated in the clinics and by private physicians

FEMALES

CLINIC PATIENTS

Site	Total	Localized	% Localized
1. Cervix	253	126	50
2. Breast	143	48	33
3. Skin	121	106	88
4. Other sites	47	12	26
5. Fundus of uterus	31	16	52
6. Buccal cavity & pharynx	25	13	52
7. Stomach	20	0	0
8. Ovary	19	3	16
9. Urinary organs	15	8	53
10. Esophagus	14	5	36

PRIVATE PATIENTS

Site	Total	Localized	% Localized
1. Skin	166	161	97
2. Breast	121	67	51
3. Cervix	217	88	69
4. Colon	50	12	24
5. Ovary	39	16	41
6. Fundus of uterus	30	15	50
7. Buccal cavity & pharynx	20	14	70
8. Urinary organs	18	12	67
9. Rectum	18	8	44
10. Other sites	17	9	53

MALES

CLINIC PATIENTS

Site	Total	Localized	% Localized
1. Skin	152	142	93
2. Buccal cavity & pharynx	64	25	39
3. Respiratory system	56	8	14
4. Prostate	40	12	30
5. Other sites	38	7	18
6. Stomach	31	5	16
7. Urinary organs	20	9	45
8. Colon	19	2	11
9. Esophagus	17	1	6
10. Leukemia	16	0	0

PRIVATE PATIENTS

Site	Total	Localized	% Localized
1. Skin	200	161	81
2. Prostate	72	54	75
3. Respiratory system	40	1	3
4. Other sites	35	17	49
5. Buccal cavity & pharynx	34	28	82
6. Urinary organs	30	18	60
7. Colon	25	4	16
8. Stomach	22	2	9
9. Rectum	9	2	22
10. Pancreas	9	2	22

diagnosed and treated in 1957. One thousand two hundred ninety-six (1,296) (765 whites and 531 negroes) new cancer cases were treated by the cancer clinics and 1,219 (1,109 whites and 110 negroes) new cancer cases were treated by private physicians in the eleven (11) hospitals maintaining cancer registries. In the cancer clinics 45% (whites

*State Board of Health.

in 1957. Your attention is especially called to the percentage of localized cases by sites.

The above tables reflect in general that there is little difference in the types of cancer handled in the cancer clinics and in private practice. However, as is to be expected, the percentage of early cancer was greater in private practice. The number of patients with localized cancer of the gastro-intestinal tract

and respiratory system was exceedingly low in males and females, in both clinic and private practice. Cancer of the reproductive organs was the most frequent type occurring in females. Six out of ten cancers of the female genital organs were early lesions in the private patients. Fifty-one percent and 33% of females with cancer of the breast in private and clinic practice had localized disease.

One cannot philosophize or conclude from the above figures. Nevertheless, it seems safe to state that progress in cancer control from the standpoint of decreasing mortality from cancer of the breast and genital organs in females can be expected. To accomplish this, earlier diagnosis of cancer of these organs is imperative. There are indications that the latter objective can be reached through routine vaginal examinations including cytologic studies and careful inspection and palpation of the breasts of female patients.

In males, since the incidence of cancer of the lungs is increasing and the number of

cases of gastro-intestinal cancer continues to be high, the immediate outlook for a decreasing mortality in this sex is not too favorable. Even with improved educational approaches to motivate males to have routine physical examinations, unless diagnostic tools and tests for the detection of early cancer of the lung and gastro-intestinal tract are refined or new more effective ones become available, their future will continue to be hazy. Nevertheless, we must routinely do rectal examinations (this should also be a part of our routine in female patients), palpate the prostate, do gastro-intestinal studies in selected cases (these are mandatory in patients with unexplained anemia or bleeding and changes in bowel habits) and request chest roentgenograms on male patients 45 years and over. Persistence in these routines detects and will continue to detect some early cancers of these organs. Yes, progress is being made against cancer in this state.

Serum Cholesterols in An Office Practice

(Continued from Page 443)

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PRESIDENT'S PAGE

In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patients' ability to pay. He should neither pay nor receive a commission for referring patients. Drugs, remedies, or supplies may be dispensed or supplied by the physician, provided it is in the best interests of the patient.

Combined billing procedures are unethical because it may tend to induce fee-splitting, jeopardize doctor-patient relationship, provide an opportunity for excessive fees, and interfere with free choice of consultants. Physicians practicing in groups, however, may present joint bills, but these must be divided in proportion to the value of services contributed by each individual participant.

It is perfectly ethical for any member of the profession to dispense drugs, remedies, or supplies to their patients provided they do not receive rebates, kick-backs, or excessive profits from them. We should always keep the idea of maintaining good relations with the public and individual patients by rendering bills commensurate with the value of the services rendered and the financial ability of the patient to pay.

From the above discussion it can readily be seen that a physician can ethically own stock in pharmaceutical concerns or in stores provided there is no exploitation of his patients or no subterfuge is employed and no unusual control is exercised upon the company by the doctor owning the stock.

During the past few years our relations with the public for many reasons have been at a low ebb, and it behooves all of us to put our shoulders to the wheel and work for the betterment of our position in the public eye. Especially should we line up solidly behind our Blue Shield Plan, thereby making it work for the best interests of the patient and physician alike. In the minds of some of our members it is far from perfect, but, at the moment, it is the best we have. Many of its objectionable features have been recently removed, and with the cooperation of the entire profession it can be made to work for the betterment of all concerned. Last, but by no means least, it will act as our strongest deterrent to socialism. Never forget for one minute that socialism is not a dead issue.

The holiday season is fast approaching. May it be a healthy as well as a happy one. To each and every member of the Medical Association I send greetings. Best wishes for a Merry Christmas and a very Happy New Year.

R. L. Crawford, M. D.
President

Editorials

THE FORAND BILL IS STILL THREATENING

This Bill with all its objectionable features will come up again in the next session of Congress. Labor organizations are already working hard toward its passage, as is announced in a pamphlet recently issued by the A.F.L.—C.I.O. This Bill is ranked second in the list of seventeen legislative objectives which these organizations intend to promote; the only priority is given to the Taft-Hartley Act, which Labor hopes will have a complete overhaul.

Surely by now all medical men are aware of what the Forand Bill provides, i. e. hospitalization and surgical care for all social security beneficiaries. The extremely high cost of such provision, and the undoubtedly bad effects on medicine by way of the tremendous promotion of socialization of medicine would certainly seem to be arguments which we must push in an effort to defeat what to all sound medical people appears to be an extremely bad piece of proposed legislation.

It does not seem likely that the study of the care of the aged recommended by the House Ways and Means Committee to the Department of Health, Education and Welfare will have been completed by the time that Congress convenes again. In that event, it is likely that the legislation will come up for consideration fairly early. Certainly it behooves everyone of us to do all that we can toward influencing our representatives in Congress to see the difficulties which the passage of this Bill would bring about, and to do all that is possible to influence them to vote against the measure.

THIRTY YEARS AFTER PENICILLIN

In October of this year there was held in Washington an important meeting and dis-

cussion of antibiotics. From it came news of new and successfully-used varieties of antibiotics and a considerable amount of information on other substances which combat infection.

Since penicillin came to our knowledge there has been developed a long line of antibiotic substances, of which only relatively a few have proven effective and safe at the same time. The search for better antibiotics continues vigorously, and every little while a new one is found which is prepared to offer greater advantages than some of the older types. With our constantly recurring problem of the development of resistance to the common varieties of the antibiotics, it is important that we produce new substances with which the pathogenic organisms have not become so casually familiar. The current gathering feeling that antibiotics have been used much too widely and too often unnecessarily in the past is a healthy promise that the development of resistance will not be so readily accomplished as it has been over the recent years.

Most encouraging reports were made at this meeting on the efficacy and lack of toxicity of a new derivative of erythromycin. This substance has been used in clinical trials in a number of cases and was found to be highly effective and lacking almost completely in side effects. It is more uniformly absorbed, produces a more predictable response, and is well tolerated. It seems to be considerably more effective than the older erythromycin or oleandomycin.

The drug of choice in severe antibiotic-resistant staphylococcus infections is new vancomycin, according to a study by Kirby and his associates at the University of Washington. They reported that ristocetin and kanamycin are definitely less active than vancomycin *in vitro*, according to comparative studies. In thirty patients with severe staphylococcus and streptococcus infections, results were generally

considered to be excellent and often dramatic in instances in which other antibiotics had failed. Dosage was 2 Gm. daily for ten days and 1 Gm. daily thereafter. No vancomycin-resistant staphylococci have been encountered by the investigators, and relatively few side-effects were observed.

During the panel discussion on the subject of the status of available antibiotics for use in staphylococcus diseases, it was agreed that vancomycin is most effective. It appears to work in lower concentration, it is more bactericidal, provides high effective blood levels, and has minimal side effects.

There was definite agreement among the members of the panel in respect to the use of antibiotics that a single substance was preferable to combinations, and they also agreed that fixed combinations are not practical. This is a feeling that many people have had since there was little opportunity to vary the doses of the several ingredients where the combinations are in fixed form. The panel also felt that the routine use of antibiotic prophylaxis in surgical procedures was not advisable except in certain selective cases, as antibiotic prophylaxis in no way serves as a substitute for aseptic technique.

THE BEDSIDE NURSE

A recent article in *The Modern Hospital* entitled "Wanted: Nurses Who Carry Their Own Lamps" makes a number of pertinent points about the current situation in nursing. The reference in the title is, of course, to Florence Nightingale and the early nurses who were strictly bedside attendants.

Present educational tendencies in nursing have carried the current crop of trainees rather far away from the older concept of the bedside ministrations to the newer idea of able administration as the prime responsibility of the nurse. Modern intricacies of hospital operation and medical techniques have demanded that the nurse receive a different type of training from that which was in vogue not too many years back. Current training then is rather in the direction of making the graduate nurse an administrator and supervisor rather

than a person who will actually work at the bedside of the patient. There is no quarrel with the thought that the first type of nurse is quite essential, but there is a contention that not all nurses are fundamentally suited to reach the positions at which they are being thrown, and that there is still a tremendous lack of the nursing care which is essential to the well-being of the patient rather than to the smooth operation of the hospital or the benefit of the nursing profession itself.

This is not the fault of the present day student nurse. It is estimated that probably only about 30% of the nurses now trained are really equipped for administrative and responsible supervisory positions, and perhaps it is not wise to assume that the individual is necessarily made competent by a more involved course of training. Even in training a nurse spends far less time at the bedside than she did some years ago.

A suggestion has been made that there be three types of nurses for hospital work. First there would be the practical nurse, who has a brief training and is allowed only small responsibility. Next there would be the bedside nurse who would have longer training, say two years, with emphasis on the actual technique of bedside nursing and not too much of the indoctrination necessary for the administrative type of nurse. Then at the highest level there would be the administrator-nurse who would be a fundamental part of the whole administrative system of the hospital, and would have the heavy responsibility of management and direction of other members of the nursing staff. Such a proposal sounds quite reasonable, and certainly in these times of scarcity of nurses it is important that any proposition be considered in an effort to remedy this unsatisfactory condition.

It would seem to be time that doctors and nurses should get together to work out some over-all scheme for supplying a great need. The Massachusetts Hospital Association has already voted that the Approving Authority for Schools of Nursing give full consideration to the establishment of a two-year Regional Nursing School Program.

STOOL GAZING

An article appearing in the *British Medical Journal* with the title above views without regret the passing of an art which appears to have arisen largely with the development of modern pediatrics. The author describes the rise and fall of what he calls the cult which was at one time dignified with the name of Clinical Coprology. He describes the eager pediatrician bending over the excreta of the infant with the enthusiasm and presumed diagnostic knowledge of a Babylonian priest inspecting the liver for prognostic signs. He describes the minute inspection of the stools which was a part of regular clinical rounds on pediatric hospital wards and speaks of the various and sundry contents of the infant's foods which were supposed to give characteristic and important changes in the movement of the bowels. At one time fats were blamed for peculiar appearances; at another protein was responsible for unusual deposits, and various noxious elements in the milk were described from time to time. Now after some seventy years of supposed importance, the art of divination from the stool seems to have declined to a point where it is only of minor interest to the man in the laboratory.

Being a pediatrician, the editor must admit that much of what is said in this very amusing as well as accurate article is quite true. He can recall a considerable amount of squinting and sniffing on the part of his fellow physicians, and he can recall considerable interest in whether or not the bacteria were Gram-negative or Gram-positive or what not. He can also agree with the writer that the passing of this ritual and the decline of the cult are probably wholesome things. However, he is not willing to put the onus of the whole now apparently futile business on the pediatrician, or to admit that it was a mere seventy years ago when the customary inspection began. In evidence he presents here a print whose date is about 1860 or earlier which depicts the very active interest on the part of a physician in the nether products of his patient. Perhaps the pediatrician developed a keener interest and brought the process to a finer state of such perfection as it might enjoy, but he has only taken a leaf from the book of some of his early predeces-



sors. At least he has had the good judgment to abandon, or nearly so, the routine which was certainly not productive of stimulation of the esthetic sensation.

CORRESPONDENCE

Dr. Joseph I. Waring, Editor:

I am enclosing a copy of an operations bulletin, received by the Medical Advisory Committee to Selective Service. It might be of interest to the doctors of the state, particularly because a number of doctors will be ordered up for examination. The ones to be ordered up are those over twenty-six years of age who have not been examined, and a re-examination will be made of all IV-F registrants. Unless some change is made, only those under twenty-six years of age, unmarried, who are eligible under the regular draft, need be concerned with any early call. The reason for the pre-induction examination on those over twenty-six, and the re-examination of present IV-F's, is to determine how many would be available if special call is necessary. I thought this might be of interest.

Sincerely yours,

Frank C. Owens, M. D.

Chairman, Medical Advisory Committee to Selective Service
Columbia, S. C.

Dear Dr. Waring:

As Chairman of the Committee on Arrangements for a Sectional Meeting of the American College of Surgeons, to be held at the Francis Marion Hotel in Charleston, January 19-21, 1959, I am writing to extend a cordial invitation from the Fellows of the College in Charleston, to members of our state association, to attend this meeting.

The program will include hospital clinics and sessions at the headquarters hotel. Some of the hotel sessions will feature a wide variety of papers on surgical subjects, panel discussions on Arterial Occlusive Disease, Management of Gastrointestinal Hemorrhage, and another on Abdominal Emergencies. Symposiums

NEWS

SOUTH CAROLINA SURGEONS

Seven South Carolina physicians were among the 1,100 have been inducted as new fellows of the American College of Surgeons.

The cap and gown ceremonies climax the annual five-day clinical congress of the world's largest organization of surgeons.

Those accepted from South Carolina were Drs. Carroll W. Bowie, Anderson; Howard A. Baker, Navy commander from Beaufort; Jennings K. Owens, Jr., of Bennettsville; Henry Donato, of Charleston; Gerald A. Barnaby, of Columbia; Lewis M. Davis, of Greer, and Albert J. Baroody, of Florence.

Dr. Julian E. Atkinson has announced the opening of offices for the practice of general medicine and surgery in Wyattsville.

Dr. Atkinson is a native of Edgefield and a graduate of The Citadel and the Medical College of South Carolina. After completing his medical schooling in 1955 he interned at the Milwaukee County Hospital.

Dr. Atkinson has just completed two years of service with the U. S. Army in Formosa, leaving there in early September.

Leta J. White, M. D. announces the opening of her office at 228 College Drive in Gaffney, South Carolina. Practice limited to pediatrics.

PUBLIC CAMPAIGN FOR POLIO VACCINATIONS TO BE RESUMED THIS WINTER

The Public Health Service has decided to resume the public educational program aimed at getting more people inoculated with the Salk poliomyelitis vaccine. The reason is that the drive of last winter and spring has fallen short of expectations. In the words of Secretary Flemming, "... we have not made nearly the progress we could and should have made during the year—a year in which for the first time there was no shortage of vaccine at any time in any area."

Upshot is that Advertising Council will again carry out a promotion campaign, with the cooperation of the American Medical Association, the National Foundation, state and local health departments and private groups.

Surgeon General Burney of Public Health Service made a report on the 1958 polio season with these highlights:

Of the population under age 40, about 53% has not had the basic three injections, and over a third has had no vaccine at all. There were 1,815 cases of paralytic polio during the first nine months of the year, 258 more than in the same period in 1957.

will be conducted on Cancer and Trauma. Luncheon sessions will be conducted at which participants in the morning programs will be expected to answer questions from the audience and to enlarge upon the subject matter covered in their morning presentations.

A reception and dinner will be held for visiting surgeons and their wives, at which Mr. Augustine T. Smythe will be the guest speaker, and sight-seeing tours and other attractions will be scheduled for the visitors.

The surgeons in Charleston would be delighted to see good representation from our state in attendance at this meeting.

Sincerely yours,
Kenneth M. Lynch, Jr., M. D., F.A.C.S.
Chairman, Advisory Committee on
Arrangements

October 10, 1958

Dear Dr. Waring,

Under separate cover I am submitting a brief article for publication in the Journal, if, of course, you deem it worthwhile. The purpose of this article is to invite the attention of the profession of the State to a very important but little known old Society, the membership of which now largely comes from the low country.

I would like this fine ancient organization to become a State Society in fact as well as in name. The name of the organization is "The Society for the Relief of Families of Deceased and Disabled Indigent Members of The Medical Profession of The State of South Carolina", known to the membership as "The Widows and Orphans Society".

There are few requirements for admission. Rule 11 Section I of the By-laws states "Any person of good moral character" is eligible. "Application must be by letter directed to the President and Members which letter may be offered to the Standing Committee and if approved by them, such candidate shall be balloted for—and if there appear a majority of votes in his favor he shall be declared duly elected and subject to the laws of the Society; PROVIDED, the said election be confirmed at the annual meeting, at which meeting, letters applying for admission shall also be considered and acted upon."

The dues are \$10.00 a year.

As President it will give me great pleasure to endorse the applications of any physicians in our State who may be interested in the aims of our Society. However, they must be of "Good Moral Character."

Very sincerely,
W. Atmar Smith, M. D.,
President.

Cited as a disturbing factor was that in six states (Michigan, New Jersey, Virginia, Texas, West Virginia and California) the majority of paralytic cases, 416 out of 781, were among children under five. Of these 416, four out of five had had no vaccine.

There is mounting evidence that incidence of polio is increasing in lower socio-economic groups. Mr. Flemming blames this on apathy, not any "insurmountable financial obstacles." He pointed out funds were available from a number of sources and that the AMA has encouraged state and local societies to organize community clinics and provide vaccinations at minimal cost.

The increase in the number of paralytic cases is no reflection on the efficacy of the vaccine. During the 3½ years of use, effectiveness rate has held at between 60 and 90%. Nor is there any evidence that properly vaccinated persons are losing their immunity.

Both Mr. Flemming and Dr. Burney expressed doubts over the need for any compulsory program of vaccinations for polio.

STATE HEALTH OFFICERS TOLD OF LONG-RANGE HEALTH PLANNING IN HEW

In an address to the Association of State and Territorial Health Officers, Secretary Flemming disclosed he was considering some long-range studies on national health objectives. While still in discussion stage, it is understood the planning may take the form of another Bayne-Jones-type report. This study, released last summer by a group of consultants to the secretary of HEW, proposed major advances in spending for medical research and education.

Asked about the level of Hill-Burton hospital construction spending for the next fiscal year, Mr. Flemming recalled that the record high total of this year (\$187 million) was voted as an anti-recession move, and that economic conditions have improved. The inference was that a lower figure might be asked of Congress next January.

Dr. Leroy Burney, PHS surgeon general, reported: (1) Asian influenza outbreaks can be expected again this winter but probably with fewer cases; a new polyvalent vaccine has been developed for the disease, (2) early in December the first full report of the continuing National Health Survey will be released, with promises of some "interesting" data, (3) PHS hopes to have bids out and ground broken by spring on the \$6.9 million National Library of Medicine building at Bethesda, Md.

STATE BOARD OF HEALTH MINUTES

September 17, 1958

Mr. James M. Daniel and Mr. William H. Duncan, along with Mr. S. J. Ulmer, Jr., Administrator of the Hospital Construction Section presented recommendations on which the following actions were taken:

(4) It was moved by Dr. King, seconded by Dr.

Platt, that the recommendation of the Hospital Advisory Council that the 1958-1959 Hill-Burton allotment and the 1957-1958 Reserve in the amount of \$3,912,250.52 be earmarked for construction percentage wise to the following categories in the amounts stated: General \$3,208,045.43 (82%); Public Health Centers \$586,837.58 (15%), and Reserve \$117,367.51 (3%), be approved. Passed.

(5) It was moved by Dr. Platt, seconded by Dr. Hanel, that the recommendations of the Hospital Advisory Council that applicants for Hill-Burton funds be required to file Parts I (Intent) and 2 (guarantee of local funds) of the application within a six-month period after date of acceptance letter, be approved. Passed.

(6) It was moved by Dr. Stokes, seconded by Dr. King, that the recommendation of the Hospital Advisory Council that whereas they are in full sympathy with the hospital needs of York County they have no alternative but to recommend that the State Agency follow the established priority list of the State Plan for 1958-1959 and recommend further that the State Agency expedite the securing of releases from those counties above York County on the priority list who do not wish to make an application for funds, be approved. Passed.

A report was made on a request from Senator-Elect Arant in Chesterfield County for permission to use the auxiliary health center at Jefferson for a proposed incoming private physician's office. A letter from Dr. Peebles to Senator-Elect Arant advised that Hill-Burton fund requirements would not allow this, although Chesterfield County may sell the health center to the town of Jefferson under certain conditions, it being brought out that the Federal Government has the right to recover an amount equal to the extent of its participation.

A report and request from the Grand Jury of Edgefield County concerning unsatisfactory sanitary conditions at the stockade was brought up. The County Health Department has inspected this area, and the State Board of Health will follow up and make recommendations.

The matter of radiation hazards was presented. The status of the Radiological Control Laboratory was reported on. Mr. W. G. Crosby is heading the laboratory.

A resume on the latest efforts to control staphylococcus infections was given.

OBSTETRICIANS ELECT DR. WATSON AS PRESIDENT

Dr. David Watson of Greenville was named president-elect of the South Carolina Obstetrical and Gynecological Society at the opening session of its annual meeting on October 18.

Dr. Albert Baroody of Florence was re-elected secretary-treasurer at the meeting in the Francis Marion Hotel. Dr. William A. Hart of Columbia moved up to the presidency, succeeding Dr. Lawrence

L. Hester, Jr., professor and chairman of the obstetric and gynecology department at the Medical College of South Carolina.

Following the business session in Charleston, the doctors heard a humorous talk by Harold S. Reeves, local authority on the Gullah dialect, during their annual banquet.

Dr. Robert Ross, professor and general chairman of the obstetrics and gynecology department at the University of North Carolina, was principal speaker for the closing session.

Catherine M. McCottry, M. D. announces the opening of her office for the practice of Obstetrics and Gynecology at 116 Smith Street, Charleston.

EYE PHYSICIANS IN ENGLAND ELECT DR. L. KENT BEST

Dr. L. Kent Best of Charleston has been elected a member of the Oxford (England) Ophthalmological Congress, a group of English eye physicians which meets annually at Oxford.

The Congress is composed mostly of eye physicians of England, Ireland, Scotland and Wales. Few physicians outside these countries are elected to membership.

G. B. Hodge, M. D. and W. C. Haggerty, M. D. announce the association of Joseph Hodge, M. D. in the practice of General, Thoracic and Cardio-Vascular Surgery at 3 Catawba Street, Spartanburg, S. C.

WANTED: OLD PHOTOS OF PHYSICIANS DRIVING ANCIENT CARS

The Illinois State Medical Society is preparing an exhibit centered around an Illinois Medical Journal article which told of the role of physicians in the development of the automobile in the United States at the turn of the century.

To help illustrate this exhibit, the Society will appreciate the loan of old photographs showing physicians at the wheels of cars of 1900-1910 vintage. Scenes showing difficulties on the road, or poor highway conditions, are especially desired. Enlargements will be made of these photographs and the originals returned undamaged.

Photographs should be accompanied by a memo giving the name and town of the physician, whether living or deceased, and the make and year of the automobile. They should be sent to Mr. John A. Mirt, Illinois State Medical Society, 185 North Wabash Avenue, Chicago 1.

John F. Ott, M. D. announces the removal of his office from 211 E. Coffee Street to 5B Vardry Street Medical Court, Greenville, South Carolina on November 1, 1958. Practice limited to diseases of infants and children.

BELL SYSTEM TELECASTS SCIENCE SHOW OF INTEREST TO MEDICAL PROFESSION

The Bell System Science Series presents its second television program devoted to the working part of the human body in "Gateways to the Mind," the story of the human senses seen over the NBC network on October 23, "Hemo the Magnificent," an earlier program in the same series, was devoted to the story of blood and the circulatory system.

Some 14 different senses are discussed in "Gateways to the Mind" in explaining how the senses function as the channels through which all knowledge of the external world is passed to the brain. Both scientific documentary film and animation are used in the program.

Dr. Wilder Penfield, noted Montreal brain surgeon, appeared on the program to explain his work in exciting sensations by direct stimulation of the brain. Dr. Hadley Cantril, Princeton University psychologist, discussed some of his experiments in sensory illusions on the telecast.

Dr. George Wald, professor of biology at Harvard, was principal advisor on the production of "Gateways to the Mind," and Dr. Frederick Crescitelli, professor of zoology at UCLA, served as consultant. The program was produced for the Bell System by Warner Brothers and stars Dr. Frank C. Baxter, who has appeared in the four earlier programs of the series. The Scientific Advisory Board, composed of ten leading American scientists, had general supervision over the production.

After its telecast on October 23, "Gateways to the Mind" was made available on 16 mm. color film by Bell Telephone companies for group showings to interested organizations.

DR. TOWNSEND NAMED HEAD OF HEALTH LABORATORY

Dr. Eleanor W. Townsend has been appointed acting director of the State Board of Health Laboratory, according to an announcement by Dr. G. S. T. Peebles, state health officer. This appointment fills the vacancy recently created by the death of Dr. Harry F. Wilson.

Dr. Townsend has been clinical pathologist in the Board of Health's Laboratory since March 1956, spending a considerable part of her time in the development of the virology service.

Born on Edisto Island, Dr. Townsend attended schools in Charleston County and in Columbia and received her pre-medical training at the College of Charleston. She received her M.D. degree from the Medical College of South Carolina and served internships at Mercy Hospital in Bay City, Mich., and Willard Parker Hospital in New York City.

She has served as instructor and associate in clinical pathology at the Medical College of South Carolina and as assistant professor of pathology and bacteriology at Emory University School of Medicine.

Dr. Townsend has been pathologist at the Kentucky Baptist Hospital in Louisville and chief of Laboratory Services at the Veterans Administration Hospitals at Mountain Home, Tenn., and Salisbury, N. C.

She was on active duty in the U. S. Naval Reserve for two years and is now a commander in the Naval Reserve in retired status.

Dr. Townsend is a member of the South Carolina Medical Association, the Southern Medical Association, the American Medical Association, the American Medical Women's Association, the American Society of Clinical Pathologists and the College of American Pathologists.

SELECTIVE SERVICE SYSTEM

Washington 25, D. C.

(Bulletin Issued September 22, 1958)

Armed Forces Physical Examination of Registrants Who Are Physicians

1. It is currently reported that too few physicians are volunteering for active duty and residency programs to meet service requirements.

2. If the present trend continues, the Selective Service System will be called upon to deliver physicians on a special call. Local boards will be expected, in anticipation of a possible special call for physicians (but not dentists), to proceed with the physical examination of all physicians who are in Class I-A or Class I-A-O and have not been examined, or who are in Class IV-F under the provisions of section 1622.44 (a) of the regulations.

3. Operations Bulletin No. 181, issued August 19, 1957, Subject: "Postponement of Armed Forces Physical Examination and Induction of Physicians and Dentists," is being amended to discontinue the postponement of the examination and induction of physicians.

4. For the purposes of this bulletin a physician is any registrant who has received the degree of bachelor or doctor of medicine.

Lewis B. Hershey,
Director

PLASTIC SURGERY BOARD CERTIFIES DR. C. P. MAGUIRE

Dr. Carter P. Maguire of Charleston has been certified as a diplomate of the American Board of Plastic Surgery.

There now are approximately 400 qualified specialists in plastic surgery throughout the United States. Maguire was one of 25 surgeons who passed a three-day written and oral examination given in Chicago prior to the annual meeting of the American Society of Plastic and Reconstructive Surgery now being held.

A Georgetown University Medical Center professor addressed the Charleston County Medical Society at Simon Baruch Auditorium on October 14.

Dr. George E. Schreiner of Washington, principal speaker, discussed "Renal Biopsy—a Correlation of Structure and Function." He is associate professor of medicine and director of renal service at the center.

Dr. John van de Erve of Charleston also spoke. His topic was "Senile Skin Lesions."

ANNOUNCEMENTS

The Southeastern Regional Meeting of the International College of Surgeons will be held at the Americana Hotel, Bal Harbour, Miami Beach, Florida, from January 4th to 7th, 1959.

This meeting has been approved for general practitioners also, by the American Academy of General Practice for Category I credit.

SURGICAL MEETING IN CHARLESTON, SOUTH CAROLINA, JANUARY 19-21, 1959

All members of the medical profession are invited to attend a three-day Sectional Meeting of the American College of Surgeons in Charleston, South Carolina, January 19-21, 1959.

Dr. Kenneth M. Lynch, Assistant Professor of Urology, Medical College of South Carolina, is Chairman of the Advisory Committee on Local Arrangements. Assisting him are the following Fellows of the College (F.A.C.S.): C. Richard F. Baker, Francis G. Cain, John C. Hawk, Jr., Robert M. Hope, Louie B. Jenkins, Pierre G. Jenkins, Frederick E. Kredel, Daniel L. Maguire, Jr., James J. Ravenel, Carroll J. Scurry, John A. Siegling.

The program will include discussions on arterial occlusive disease, abdominal emergencies, management of gastrointestinal hemorrhage, trauma, cancer, common duct strictures, massive hemoptysis, acute hand injury reconstruction, cholecystitis, and many more topics of current concern. An exceptional program of medical motion pictures will also be shown.

The Fellowship Luncheon, featuring a panel discussion on College activities, with a question period, will be presided over by Dr. Newell W. Philpott, Montreal, President, The American College of Surgeons, and will include the following participants: Dr. I. S. Ravdin, Philadelphia, Professor of Surgery, University of Pennsylvania School of Medicine, and Chairman, Board of Regents, The American College of Surgeons; Dr. Joseph M. Donald, Birmingham, Associate Professor of Surgery, Medical College of Alabama, and Member, Board of Regents; Dr. Howard H. Bradshaw, Winston-Salem, Professor of Surgery, Bowman Gray School of Medicine, and Chairman, Board of Governors; Dr. Frederick E. Kredel, Charleston, Professor of Surgery, Medical College of South Carolina, Dr. Roderick MacDonald, Rock Hill, S. C., Staff, St. Phillip's Mercy and York County Hospitals, Governors; and from the College Staff, Dr. Paul R. Hawley, The Director, Dr. H. P. Saunders, Associate

Director, and Doctors George W. Stephenson and James B. Mason, Assistant Directors.

A preliminary program follows:

Dr. Kenneth M. Lynch, Jr., Charleston, will preside over the following opening session Monday morning, January 19:

Splenectomy for Hypersplenism. R. Randolph Bradham, Charleston.

Causes of Acute Abdominal Pain, A Cinematic Survey. Hilger Perry Jenkins, Chicago.

Endometrial Cancer: Diagnosis and Treatment. Newell W. Philpott, Montreal.

Dr. John A. Siegling, Charleston, will preside over the following Symposium on Trauma:

The Management of Acute Chest Injuries. Rudolf J. Noer, Louisville.

The Management of Abdominal Injuries. Hu Crim Myers, Philippi, W. Va.

Pitfalls in Treatment of Fractures. Jack Wickstrom, New Orleans.

Dr. Felda Hightower, Winston-Salem, will preside over the Monday afternoon session, which includes the following reports:

The Role of Surgery, Hormones and Radioisotopes in the Management of Thyroid Cancer. Colin G. Thomas, Jr., Chapel Hill.

Esophageal Obstruction. Murdock S. Equen, Atlanta.

Tumors of the Neck. Robert L. Brown, Emory University.

A panel on Arterial Occlusive Disease will follow, with William H. Muller, Jr., Charlottesville, as moderator, and participants Keith S. Grimson, Durham, Paul W. Sanger, Charlotte, J. Manly Stallworth, Charleston.

Dr. Leland J. Brannon, Columbia, S. C., will preside over the following Tuesday morning session:

Stricture of the Common Duct, Etiology, Prevention and Treatment. Harwell Wilson, Memphis.

Massive Hemoptysis: Diagnosis and Management Including Emergency Lobectomy. James D. Hardy, Jackson.

Radiation Hazards in Diagnostic Roentgenology. Ted F. Leigh, Emory University.

A luncheon will follow, with questions regarding the above reports. Dr. John J. Farrell, Miami, will preside.

Dr. John C. Hawk, Jr., Charleston, is presiding officer for the Cancer Symposium and the panel to be held Tuesday afternoon:

Symposium on Cancer:

Neurosurgical Procedures for Relief of Pain in Cancer. A. Earl Walker, Baltimore.

Hypophysectomy and Adrenalectomy. David M. Hume, Richmond.

Chemotherapy of Neoplastic Diseases. Ralph Wayne Rundles, Durham.

Panel on Management of Gastrointestinal Hemorrhage:

Moderator: Frederick E. Kredel, Charleston.

Collaborators: Lonie B. Jenkins, Charleston, Har-

well Wilson, Memphis, James D. Hardy, Jackson.

There will be an informal reception and dinner Tuesday evening, with Dr. Kenneth M. Lynch, Jr., Charleston, presiding.

Dr. Fred H. Bowen, Jacksonville, presides on Wednesday morning:

The Methods and Advantages of Reconstruction at the time of Acute Hand Injuries. Raymond M. Curtis, Baltimore.

Some Problems in Homologous and Heterologous Tendon Transplants. Erle Peacock, Jr., Chapel Hill.

The Challenge of Carcinoma of the Breast. Murray M. Copeland, Washington.

Neurosurgery of the Cerebral Vascular Lesions. Edgar F. Fincher, Emory University.

Treatment of Malignancy by the Isolation-Perfusion Technic. Oscar Creech, Jr., New Orleans.

A luncheon will follow, with questions regarding the above reports. Dr. Champ Lyons, Birmingham, will preside.

The following reports will be presented at the Wednesday afternoon session:

The Origin and Interpretation of Murmurs in Coarctation of the Aorta. Frank R. Johnston, Winston-Salem.

The Postgastrectomy Syndrome—Its Prevention and Treatment. Edward R. Woodward, Gainesville, Fla.

Subject to be announced. Champ Lyons, Birmingham.

Cholecystitis—Early Versus Late Surgical Management. John J. Farrell, Miami.

A panel on Abdominal Emergencies will follow, with Robert J. Coffey, Washington, as moderator, and participants Howard H. Bradshaw, Winston-Salem, John D. Martin, Jr., Emory University, William H. Moretz, Augusta, and Richard T. Myers, Winston-Salem.

The Motion picture program will include the following films and authors:

Thyroidectomy. Richard B. Cattell, Boston.

Congenital Atresia of the Esophagus. William L. Riker, Arthur DeBoer, Willis J. Potts, Chicago.

Staphylococcal Infections. H. Rocke Robertson, Vancouver, British Columbia.

Median Sternotomy and Elective Cardiac Arrest in Open Heart Surgery. Frank L. Gerbode, San Francisco.

Open Heart Surgery. William H. Muller, Jr., Charlottesville.

Acute Gallbladder Disease. Allen M. Boyden, Portland.

Meconium Ileus and the Meconium Plug Syndrome. Donald M. Glover, Cleveland.

The Complete Gynecological Examination. Frederick J. Hofmeister, Milwaukee.

Pericardiectomy. Harris B. Shumacker, Jr., Indianapolis.

Surgical Considerations of Occlusive Disease of Abdominal Aorta and Iliac and Femoral Arteries based

on Experience with 803 Cases. Michael E. DeBakey, Houston.

Dr. H. Prather Saunders, Associate Director, The American College of Surgeons, is in charge of all Sectional Meetings for the College.

DEATHS

DR. F. L. MARTIN

Dr. Frank L. Martin, well known physician of Mullins, died November 9, 1958 following an illness of six weeks.

Dr. Martin was born in Robeson County, N. C., August 6, 1887. He was a graduate of Clemson College and the Medical College of South Carolina where he was a member of Phi Chi Medical Fraternity. Upon graduation from medical school, he practiced at Blenheim in Dillon County for two years before coming to Mullins in 1914.

Dr. Martin was a member of the Board of Trustees of the Medical College of South Carolina, a member of the American Medical Association, the State Medical Association, and the Pee Dee Medical Association. He was also a member of the staff of the Mullins Hospital.

DR. HARRY WILSON

Dr. Harry F. Wilson, 54, director of the State Board of Health Laboratory, died at the Veterans Hospital October 23.

Doctor Wilson was born in Orangeburg County. Following his internship at Roper Hospital in Charleston, he entered private practice there and later accepted a position with the State Board of Health. He served as health officer of Horry County for four years and a year as health officer of Beaufort County. He also served as health officer of Dillon-Marion Health District, and was appointed director of the Division of Industrial Health of the State Board of Health in 1936.

He received his B.S. degree from Clemson in 1924, the M.D. degree from the Medical College of South Carolina in 1928 and the M.P.H. degree from Johns Hopkins University in 1934. He completed several courses at Princeton University, the Communicable Disease Center Laboratory USPHS; Atlanta, Ga.; Army Medical Center at Washington, D. C. and the U. S. Naval Base at Jacksonville, Fla.

Doctor Wilson served as director of the Division of Industrial Health until July, 1941, when he was called to active duty as a major in the Medical Corps of the United States Army. His first assignment was with the 29th Division at Fort George Meade, Md. He was later transferred to the Medical Division, Office of the Chief Chemical Warfare Service, Washington, D. C.

In November of 1943 he became director of the Toxicological Research Laboratory, Technical Com-

mand, Edgewood Arsenal, Md. After a tour of duty of six months at Edgewood he was transferred back to Washington. He attended the School of Military Government at Princeton University and was sent to Columbia Medical Center in New York City for refresher courses in tropical diseases.

Doctor Wilson served overseas for 11 months and participated in the Battle of the Philippines and the Okinawan campaign. His last assignment on Okinawa was post surgeon for army ports, headquarters at Naha.

Doctor Wilson was promoted to the rank of lieutenant colonel in 1942 and became a full colonel in January of 1946.

He was awarded the following campaign ribbons for his Army service: American Defense, Armed Forces Reserve, American Theater, Asiatic-Pacific Theater with two battle stars, Victory, Occupation (Japan) and the Philippine Liberation. He was awarded the Cross of Military Service by the United Daughters of the Confederacy in 1951.

Following his release from active duty in 1946, he returned to the State Board of Health and became director of the division of Industrial Health. He was appointed acting director, Division of Laboratories, State Board of Health, in July, 1947, and was appointed director of the laboratory in 1949, which position he held until his death.

Doctor Wilson was active in the Army Reserve program and was appointed commanding officer of the 396th Evacuation Hospital in August, 1947. In 1953 he was appointed commanding officer of the 396th general hospital when the unit was activated.

He was membership chairman for the South Carolina Department, Reserve Officers Association, for 1952. He was surgeon of the association for the years 1952-54. He was a member of the executive committee of the South Carolina Public Health Association for a three-year term. He was a charter member of the Businessmen's Sunday School Bible Class.

Doctor Wilson was an active member of the following organizations: American Medical Association, South Carolina Medical Association, South Carolina Public Health Association, Columbia Medical Society, the American Legion, Reserve Officers Association of the United States and the Phi Rho Sigma fraternity.

AN INVITATION: To a doctor interested in general practice to visit JEFFERSONVILLE, TWIGGS COUNTY, GEORGIA, new nine room office, and new five room residence, rent free for six months. Contact H. C. Swearingen, Jeffersonville, Georgia. Phone—2192.



BLUE CROSS . . . BLUE SHIELD



Blue Cross insurance has a distinctive basic philosophy. It is: Blue Cross seeks to insure against the entire necessary costs of acute illness which requires hospital treatment; and at a premium rate which is uniform throughout the territory of any given plan. These two features make Blue Cross unlike any other insurance.

Instead of limiting benefits to fixed dollars per day or per illness, Blue Cross of necessity has to have other limitations. These are: the illness must require hospital treatment; it must be acute; and all ancillary services must be consistent with the therapeutic management of the illness for which the patient was hospitalized.

These restrictions eliminate hospital benefits for: the treatment of minor illnesses; the treatment of chronic illnesses; domiciliary care of the aged and the chronic invalid; and hospital admissions, primarily or principally for diagnostic study. Every Blue Cross contract spells out these restrictions more or less clearly. They limit benefits for the treatment of uncomplicated tuberculosis, and of nervous and mental diseases to two weeks per contract year, and then only if the treatment be given in a general acute disease hospital. The theory which allows any benefits at all for these conditions is that the true condition might not be recognized before hospitalization, or it might not be possible to hospitalize in a special hospital immediately after the condition is recognized. The South Carolina Blue Cross Plan allows minimal and token benefits only for hospital care in connection with admissions primarily and principally for diagnostic studies. This exception to full compliance with Blue Cross principles has been costly in disappointment based on misunderstanding, in ill will, and in difficulties of fair administration. Benefits for diagnostic admissions should never have been allowed, and they should be discontinued. Benefits for diagnostic procedures, which are not closely allied to the therapeutic handling of an acute illness, should not be expected nor should they be allowed. These several exclusions apply to admissions for prophylactic health examinations, those to confirm or deny clinical diagnoses, suspicions, or impressions, progress studies, as in treated ulcers and healing fractures, those done to relieve the apprehension of a patient who attributes grave significance to some minor symptom, and those done to satisfy a doctor's whim or to carry out his routine practice.

It is a recognized insurance principle that insurance can only protect against unexpected loss which cannot be prevented. To include unlimited diagnostic admissions under Blue Cross benefits would be a very dangerous violation of that principle. It would protect

the insured against costs occasioned by his convenience or by his anxieties and against costs of prophylactic examinations, which even if wise are not a part of the costs of treatment of acute illness. Too frequently they would protect him against the costs of satisfying diagnostic curiosity, or of carrying out a diagnostic routine or against the expense incident to his going from doctor to doctor and from hospital to hospital. If it were expedient to attempt such wide coverage, it would be impossible to determine a sustaining rate, and if an experimental rate were tried out it would have to be so high that only a minority of insured groups or individuals would pay it.

Somewhat akin to hospital admissions primarily or principally for diagnostic studies, are diagnostic studies, either of a general and prophylactic nature or those of more limited extent, ordered during the hospital residence of a patient already under treatment for a covered acute illness. Such studies are usually made for the convenience of the patient or to save him a fee. Blue Cross is not only concerned with the fact that in such cases it is expected to pay that fee, but experience has shown that far too often the length of hospital stay is increased in order that the study might be made. The convenience of the patient, of his doctor, of the radiologist, of the pathologist or of the hematologist should not be a factor in aiding the patient to receive a benefit not covered by his insurance contract. It would be so easy and of such tremendous help, if the doctor explained to the patient and notified the hospital business office that these examinations are not covered services.

Every hospital bill is examined by Blue Cross to see if any uncovered services have been listed. If it appears that they have, the bill has to be further examined, frequently letters have to be written to the hospital or to the doctor, and replies awaited before the bill can be paid. This delay is very expensive and annoying to the hospital, it is frequently annoying to the doctor, and it often angers the patient. Of course, cases like that increase the administrative expenses of the Plan.

X-ray men cannot be too vocal in their criticism of the number and kinds of x-ray studies they are called upon to make. Several have told the writer privately that many unnecessary studies are made, that many are ordered without adequate preparation of the patient and without recorded clinical observations suggesting need for x-ray study.

To eliminate all Blue Cross coverage of all diagnostic studies, as has been suggested, would violate the principle of paying for all of the necessary hospital services in connection with treatment of acute

illnesses. However, willful abuse of that provision, unsuspecting overutilization of it by the doctor, who many times does not know that his patient has hospital insurance, and careless utilization of it have imposed a terrific unnecessary financial burden upon the South Carolina Plan. This burden has played an important part in the recurring necessity to increase premium costs which it has experienced. Excessive utilization, overutilization, and payment for undetected, uncovered services in the hospital bill may ultimately wreck the Plan. High premiums have already restricted the sale of Blue Cross insurance in a highly competitive field, in which sales effort is frequently none too ethical.

The problems of utilization of hospital insurance have worsened progressively for many years. There are recognized reasons for this, all of which are understandable. It is more difficult to provide family nursing care. Hospital beds are more readily available. Even the smaller community hospitals are equipped with x-ray and other laboratory facilities. Doctors being graduated now are more dependent upon and familiar with the assistance and guidance of laboratory examinations in diagnosis and treatment than are the older men. Also there seems to be a restlessness and haste to confirm or to rule out a suspected diagnosis. There seems to be an ever increasing disinclination to give time, that great healer, an opportunity to act, and a dislike of using a remedy in a dual capacity of diagnostic test and therapeutic agent, i. e. belladonna in suspected cardiospasm or spastic colon.

The second basic philosophical principle of Blue Cross insurance is that of charging a uniform rate throughout a plan's territory for its several contracts. This principle is called that of community rating. This principle is included in Blue Cross philosophy because in practice it forces those insured groups with low loss ratios to help bear the costs of insuring groups with higher loss ratios. The rate is determined on the basis of the average loss ratio experienced by the plan. This is a principle similar to that employed by doctors when they charge the richer more than they do the poorer in order that they may care for the poorer.

To be in a competitive position at all, and to be able to offer hospital insurance to high loss ratio groups without wrecking the plan, South Carolina Blue Cross has had to give up uniform community ratings—at least for a time. It is employing three or perhaps four scheduled rates for similar contractual coverages. Each group's experience is examined from time to time, and the rate necessary to balance its loss ratio is determined, and it is charged that rate. That means that the high risk groups must carry their own financial burden with little or no help from low risk groups. It also means that the high risk groups and non-group subscribers have to pay such a high price for the insurance which they need even more than low utilization groups, that the cost is almost prohibitive. There is also a greater temptation to chisel and to overutilize when the price paid is so high.

Community differences in hospital charges, availability of hospital beds, the attitude of physicians and the people toward hospitalization for minor illnesses, the community incidence of prophylactic health examinations, with routine x-ray examinations, ECGs, etc. are reflected in the differences in health insurance loss ratios. These differences are so great between the areas of actual or probable highest loss ratios and those of actual or probable lowest loss ratios, that a premium rate based on an average loss ratio would be unfairly low in one area and unfairly and non-competitively high in another. It is because of those differences, that the South Carolina Plan has gone to a modified plan of loss ratio rating.

There seems to be an increasing trend by our doctors and by our Plan personnel to favor co-insurance in an effort to reduce improper utilization of hospital insurance. Any type of co-insurance, whether it be by requiring the insured to pay a uniform amount on each hospital bill, or by limiting the benefits for ancillary services to some maximum figure per hospital admission or per contract year, or by requiring the payment of a given percentage of all charges for ancillary services, drugs, etc., violates the Blue Cross principle of paying the entire hospital costs for the treatment of acute illnesses. The only justification for departure from that principle is the well founded belief that there are employed rather generally in the treatment of bona fide recompensable acute illness, excessive ancillary services and excessive unnecessarily expensive drugs and that there is a widespread tendency to hospitalize minor illnesses for convenience rather than through necessity.

The basic causes for the steadily increasing costs of sickness insurance, reflected in either increasing premiums or decreased benefits, have been discussed. These same causes apply to the increasing costs of illness without regard to insurance. Insurance costs reflect general costs of illness. Is there any remedy? There are many students of the problem who think that there is. These students include state insurance commissioners and Blue Cross directors and other personnel. Unfortunately so far as I know, they do not include hospital directors and doctors to any significant extent. There is no remedy, if hospitals and doctors and the consuming public desire that unrestricted hospital care be provided for any and all illnesses and for prophylactic and diagnostic examinations. If that is their desire, then the sooner Blue Cross withdraws from the field of hospital insurance and leaves it to the commercial companies, the better. To be able to continue to operate would require abandonment of the basic philosophy of Blue Cross and its conversion into just another insurance company of the mutual type.

Should Blue Cross principles be abandoned, there will result an inability of a great segment of the population to buy sickness insurance either because of its excessive cost or because they will not be prime insurable risks. Neither will they be able to pay the high costs of medical care without insurance. Not only

will they suffer, but the hospitals will suffer from increasingly large assets tied up in bills receivable, perhaps also with increasingly large numbers of empty beds. The doctor will suffer from a similar increase in accounts receivable. He will have an increased ratio of home practice. He will experience frustration by trying to practice with the thought ever present that costs must be kept at a minimum. So many people will be so seriously involved with frustrating difficulties, that a demand for relief will be inevitable. The only source of relief will be government compulsory universal insurance. If that should come, it will not only apply to hospital care. It will include professional care as well.

There is an alternative. It is based upon the fact that Blue Cross is a cooperative effort by hospitals,

doctors and the subscribing public. If each individual of each of these cooperating groups can bring himself to feel deeply and earnestly that Blue Cross is a good thing to keep, and if the members of each group will work together at all times to protect Blue Cross from abuse by either the ignorant, the careless, or the avowed chisler, it can be saved. To do this will require probably that each of those act as a self appointed monitor to detect and report abuses. Finally, in the interest of the little man who needs good medical care most frequently, a concerted effort should be made by hospitals and by the medical profession to bring down the costs of good care. That this can be done without impairing its quality, this writer firmly believes.

J. Decherd Guess, M. D.

REPORT ON ACTIONS OF THE HOUSE
OF DELEGATES
AMERICAN MEDICAL ASSOCIATION
107th ANNUAL MEETING
JUNE 23-27, 1958
SAN FRANCISCO

The United Mine Workers of America Welfare and Retirement Fund, Social Security coverage for self-employed physicians, relations with voluntary health organizations, veterans' medical care, the Medicare program, the Association's Washington Office and over-all legislative system, the medical aspects of hypnosis and the advertising of over-the-counter medications were among the variety of subjects acted upon by the House of Delegates at the American Medical Association's 107th Annual Meeting held June 23-27 in San Francisco.

Dr. Louis M. Orr, urologist of Orlando, Fla., was chosen unanimously as president-elect for the coming year. Dr. Orr, who in recent years has been vice speaker of the House of Delegates and chairman of the A.M.A. Committee on Federal Medical Services, will become president of the American Medical Association at the June, 1959, meeting in Atlantic City. He then will succeed Dr. Gunnar Gundersen of La Crosse, Wis., who became the 112th president at the Tuesday night inaugural ceremony in the Rose and Concert Rooms of the Sheraton-Palace Hotel.

The 1958 Distinguished Service Award of the American Medical Association was voted to Dr. Frank Hammond Krusen, professor of physical medicine and rehabilitation at Mayo Foundation, Rochester, Minn., for his outstanding achievements and contributions in the field of physical medicine and rehabilitation. For only the fourth and fifth time in A.M.A. history, the House also approved special citations to laymen for outstanding service in advancing the ideals of medicine and contributing to the public welfare. Recipients of these awards were Mrs. Charles W. Sewell of Otterbein, Ind., who has spent 45 years in rural health work, and Gobind Behari Lal, Ph.D., dis-

tinguished science writer and Pulitzer prize winner.

With half a day of the meeting still to go, total registration Thursday night had reached 37,520, including 13,034 physicians.

United Mine Workers

Major discussion of relations between medicine and the UMWA Welfare and Retirement Fund centered on a reference committee report which concurred in a Board of Trustees opinion that final action on two resolutions adopted in December, 1957, should be postponed until the final report of the Commission on Medical Care Plans is received.

One of those resolutions, Number 20, declared that "a broad educational program be instituted at once by the American Medical Association to inform the general public, including the beneficiaries of the Fund, concerning the benefits to be derived from preservation of the American right to freedom of choice of physicians and hospitals as well as observance of the 'Guides to Relationships Between State and County Medical Societies and the UMWA Welfare and Retirement Fund' adopted by this House last June." The other resolution, Number 24, called for the appropriate A.M.A. committee or council to engage in conferences with third parties to develop general principles and policies which may be applied to their relationships with members of the medical profession.

In explaining its position that final action on the two resolutions should be taken only after proper study, the reference committee said it "anticipates that the final report of the Commission on Medical Care Plans will contain recommendations serving to clarify the relationships between the medical profession, the patient and third parties, and the committee has been assured that this can be expected." The committee also urged the Commission to present its recommendations no later than December, 1958.

The House of Delegates, however, by a vote of 110 to 72, adopted a floor amendment "that this section of the Reference Committee report be

amended to show that our A.M.A. Headquarters Staff is directed, under supervision of the Board of Trustees, to proceed immediately with the campaign which was originally ordered at Philadelphia last December, that no further delays will be tolerated, and that the Council on Medical Service be relieved of any further responsibility in this matter."

Social Security Coverage

In considering seven resolutions dealing with the inclusion of self-employed physicians under the Social Security Act, the House disapproved of three which called for polls or a referendum of the A.M.A. membership, one which favored state-by-state participation in Social Security, and two which called for compulsory inclusion on a national basis. Instead, the House adopted a resolution pointing out that "American physicians always have stood on the principle of security through personal initiative," and reaffirming unequivocal opposition to the compulsory inclusion of self-employed physicians in the Social Security system.

On the question of polls, the House expressed the opinion that any poll should be taken on a state-by-state basis and the results transmitted to the A.M.A. delegates from that state. It also pointed out that since there is no provision in the Constitution and Bylaws for a referendum of members, such a referendum would usurp the duties and prerogatives of the House of Delegates, which is the Association's policy-making body.

Voluntary Health Organizations

Dealing with problems that have arisen in the raising and distributing of funds since development of the concept of united community effort, the House adopted the following statement offered in the form of amendments from the floor:

"1. That the House of Delegates reiterate its commendation and approval of the principal voluntary health agencies.

"2. That it is the firm belief of the American Medical Association that these agencies should be free to conduct their own programs of research, public and professional education and fund raising in their particular spheres of interest.

"3. That the House of Delegates respectfully requests that the American Medical Research Foundation take no action which would endanger the constructive activities of the national voluntary health agencies.

"4. That the Board of Trustees continue actively its studies of these perplexing problems looking forward to their ultimate solution."

Veterans' Medical Care

Pointing out that the Federal government spent \$619,614,000 on hospitalized medical care of veterans in VA hospitals in 1957, of which about 75 per cent had non-service-connected disabilities, and that ways and means of obtaining economy in Federal government are allegedly being sought by Congress at this

time, the House urged Congressional action to restrict hospitalization of veterans at VA hospitals to those with service-connected disabilities. It also recommended that the American Medical Association suggest to the Dean's Committees that they restrict their activities to Veterans Administration hospitals admitting only patients with service-connected disabilities.

The Medicare Program

In disapproving a resolution calling for repeal, modification or amendment of Public Law 569, the House took the position that desired changes in the Medicare program could be accomplished through modification of the present implementing directives without the necessity for new legislation. The House reaffirmed the action taken last year in New York recommending that the decision on type of contract and whether or not a fee schedule is included in future contract negotiations should be left to individual state determination. Also reaffirmed was the Association's basic contention that the Dependent Medical Care Act as enacted by Congress does not require fixed fee schedules; the establishment of such schedules would be more expensive than permitting physicians to charge their normal fees, and fixed fee schedules would ultimately disrupt the economics of medical practice.

Washington Office

The House adopted a resolution requesting the Board of Trustees to make an immediate survey and re-evaluation of "the functions and effectiveness of the over-all A.M.A. legislative system, including the Washington office, in the light of present-day needs of the government, public and medical profession alike for effective liaison between government and medicine on all matters affecting the public's health and adequate, prompt and accurate transmittal to the full membership of the A.M.A. of information on all current public issues in which the physician has a direct interest." The House asked that the Board of Trustees implement, as rapidly as possible, all changes and additions that its survey discloses are desirable to achieve the basic purpose of the resolution, "effective public and government relations."

Medical Aspects of Hypnosis

A Council on Mental Health report on "Medical Use of Hypnosis" was approved by the House, which recommended that it be published in the Journal of the American Medical Association with bibliography attached. The report stated that general practitioners, medical specialists and dentists might find hypnosis valuable as a therapeutic adjunct within the specific field of their professional competence. It stressed, however, that all those who use hypnosis need to be aware of the complex nature of the phenomena involved. Teaching related to hypnosis should be under responsible medical or dental direction, the report emphasized, and should include the indications and limitations for its use. The report urged physicians and dentists to participate in high level research on

hypnosis, and it vigorously condemned the use of hypnosis for entertainment purposes.

Over-the-Counter Medications

The House endorsed recommendations by the Public Relations Department that:

The A.M.A. join with other interested groups in setting up an expanded voluntary program, coordinated by the National Better Business Bureau, which will seek to eliminate objectionable advertising of over-the-counter medicines.

The A.M.A. counsel with the National Better Business Bureau in the selection of a physicians' advisory committee.

The established facilities of the A.M.A., such as the Chemical Laboratory, the offices of the various scientific councils, and the Bureau of Investigation, be made available, so far as is feasible, to aid in the carrying out of this program.

The Public Relations Department continue its liaison work with the various groups involved and assist in the development and operation of this program in any way possible.

The A.M.A. become a sustaining member of the National Better Business Bureau, giving evidence of its willingness and desire to support this organization in its worthwhile activities.

Miscellaneous Actions

Among a wide variety of actions on many subjects, the House also:

Adopted amendments to the Constitution and By-laws which eliminate the separate offices of Secretary and Treasurer, combining them into one, and which change the titles of the General Manager and Assistant General Manager to Executive Vice President and Assistant Executive Vice President;

Recommended the appointment of a Committee on Atomic Medicine and Ionizing Radiation and suggested that it concern itself with informing the American public on all phases of radiation hazards related to the national health;

Approved in principle the admission of the Virgin Islands Medical Society as a constituent society of the American Medical Association;

Commended the Federal Food and Drug Administration for its untiring efforts in behalf of the public and the profession, and urged all states to review and strengthen their food and drug laws;

Approved the "Suggested Guides for the Organization and Operation of Medical Society Committees on Aging," submitted by the Council on Medical Service;

Commended the Committee on Medical and Related Facilities of the Council on Medical Service for its report on the Hill-Burton Study and approved its recommendations;

Requested that any funds provided under the Public Assistance provisions of the Social Security Act for medical care of the indigent be administered by a voluntary agency such as Blue Shield on a cost plus basis or by a specific agency established by the

medical society of the state in which indigent care is rendered;

Directed the Board of Trustees to study problems pertaining to licensure by reciprocity and to consult with the Federation of State Medical Boards in an attempt to find a satisfactory solution;

Urged all members of the House of Delegates to give full consideration to the preliminary report of the Committee on Preparation for General Practice and to submit comments and suggestions to that committee;

Expressed the opinion that some operating room experience is valuable and necessary training for all nurses;

Recommended that general hospitals, wherever feasible, be encouraged to permit the hospitalization of suitable psychiatric patients, and

Approved a National Interprofessional Code for physicians and attorneys prepared by the joint liaison committee of the American Medical Association and the American Bar Association.

Opening Session

At the Monday opening session Dr. David B. Allman, retiring A.M.A. president, urged every physician to rededicate himself to the service of mankind and every medical society to strengthen its disciplinary system "to prevent the very few from besmirching the vast majority of us." Dr. Gundersen, then president-elect, said the Association is moving ahead in finding the best possible ways to serve both the public and the medical profession, and he declared there is no reason to believe that its influence and impact will not continue to grow in the times ahead. The Goldberger Award in clinical nutrition was presented to Dr. Virgil P. Sydenstricker, professor emeritus of medicine at the Medical College of Georgia.

Inaugural Ceremony

Dr. Gundersen, in his Tuesday night inaugural address, called upon the medical profession to accept its full responsibilities in promoting better world health, brotherhood and peace, adding that "the time has come when medical statesmanship must be used to augment the methods of political diplomacy." Dr. Gundersen also presented the Distinguished Service Award to Dr. Krusen and the special layman citations to Mrs. Sewell and Dr. Lal. The Shrine Chanters of Oakland, Calif. provided choral numbers during the program.

Election of Officers

In addition to Dr. Orr, the new president-elect, the following officers were selected by the House on Thursday:

Dr. W. Linwood Ball of Richmond, Va., vice president; Dr. E. Vincent Askey of Los Angeles, re-elected speaker, and Dr. Norman A. Welch of Boston, vice speaker.

Dr. Warren W. Furcy of Chicago was elected for a five year term on the Board of Trustees, succeeding Dr. E. S. Hamilton of Kankakee, Ill. Dr. Raymond M. McKeown of Coos Bay, Ore., was re-elected for a

five year term, and Dr. R. B. Robins of Camden, Ark., was named to fill the unexpired term of Dr. F. J. L. Blasingame. Dr. Leonard W. Larson of Bismarck, N. D., was elected chairman of the Board at its organizational meeting after the Thursday elections.

Dr. George A. Woodhouse of Pleasant Hill, Ohio, was renamed to the Judicial Council. Elected to the Council on Medical Education and Hospitals were Dr. Leland S. McKittrick of Brookline, Mass., to succeed himself, and Dr. John V. Bowers of Madison, Wis., to succeed Dr. Victor Johnson of Rochester, Minn.

Dr. R. B. Chrisman, Jr., of Coral Gables, Fla., and Dr. J. F. Burton of Oklahoma City, Okla., were re-elected to the Council on Medical Service. For the same Council, Dr. Russell B. Roth of Erie, Pa., was named to fill the unexpired term of Dr. H. B. Mulholland of Charlottesville, Va., resigned.

Three members were elected to the Council on Constitution and Bylaws: Dr. William Stovall of Madison, Wis., to succeed Dr. Stanley H. Osborn of

Hartford, Conn.; Dr. William Hyland of Grand Rapids, Mich., to fill the unexpired term of Dr. Floyd S. Winslow, deceased, of Rochester, N. Y., and Dr. Walter Bornemeier of Chicago, to replace Dr. Furey.

The House approved a Board of Trustees announcement that Miami Beach will replace Chicago as place of the 1960 Annual Meeting, and New York will be the site of the 1961 Annual Meeting. Action was postponed on selection of the city for the 1962 Annual Meeting.

Rising votes of appreciation were given to Dr. Hamilton; Dr. George F. Lull, retiring secretary, and Dr. J. J. Moore, retiring treasurer.

At the Wednesday session of the House the Illinois State Medical Society made another record state society contribution to the American Medical Education Foundation by turning over a check for \$177,500 to Dr. Lull, now foundation president.

F. J. L. Blasingame, M. D.

Executive Vice President

American Medical Association

Excerpts from the
REPORT OF THE
EXECUTIVE DIRECTOR
TO THE
STATE MEDICAL ADVISORY
COMMITTEE OF THE
CRIPPLED CHILDREN SOCIETY
OF SOUTH CAROLINA, INC.

The Crippled Children Society of South Carolina, Inc. is in its twenty-fourth year of serving the handicapped in South Carolina. This report shows progress in many areas due primarily to the wise guidance of the Medical Advisory Board. The staff and the hundreds of dedicated volunteers have also given unselfishly of time, effort and money in carrying on the work of the Easter Seal Society throughout South Carolina.

The Crippled Children Society of South Carolina, the state affiliate of the National Society for Crippled Children and Adults, has local affiliates in each of the 46 counties with an additional chapter in the Rock Hill area.

Easter Seal services supplement and extend but do not duplicate the work of any other agency or organization.

CARE AND TREATMENT SERVICES:

I. STATE SOCIETY'S SERVICE PROGRAM

A. Cerebral Palsy Clinic

15 held during past fiscal year.

342 referrals, with therapy prescribed or other necessary follow-up.

Clinic staff includes:

Orthopedic surgeon with special training in cerebral palsy (holds membership in The American Academy for Cerebral Palsy).

Registered Physical Therapist

Registered Occupational Therapist

Registered Speech Consultant

Orthopedic brace maker

Psychological services

Registered nurse (volunteer)

Nurse's aide (volunteer)

Orderly

B. Treatment Center located in State Headquarters, 1517 Laurel Street, Columbia, South Therapy administered on written medical prescription

C. Educational Program

1. Professional Education

Annual Cerebral Palsy Seminar presented at Medical College of South Carolina

Teacher-training workshops sponsored in cooperation with State Colleges

Scholarships provided for postgraduate therapy training

Staff assistance given for *Exceptional Child Study Project* of the Southern States Work Conference

Sponsored one-day professional program with approximately 100 special education teachers and administrators attending during 1958 S. C. Education Association meeting. Dr. Lloyd M. Dunn, coordinator of Special Education and Professor of Education, George Peabody College for Teachers, Nashville, Tennessee, was the Easter Seal Society's guest consultant.

2. Parent Training

Parent Conferences

Printed materials prepared especially for parents

Exhibits

Parents Bookshelf (loan library)

Visual aid series of slides: "A Child's Road to Independence", which offers guidance in the problems and pleasures to be met in everyday life of the family of a crippled child. The five sets are available on loan.

3. *Loan Library*

The Easter Seal Society's Loan Library of professional books and pamphlets has been substantially increased through the creation of "The Miss Lucile Lindsay Memorial Library Fund". All books are available on loan to professional workers.

D. *State Board of Health Requests Financial Assistance*

R. W. Ball, M.D., Director of the Crippled Children's Division of the State Board of Health, contacted the Easter Seal Society February 3, 1958 in regard to the curtailment of Health services due to a lack of funds to complete the Board of Health's fiscal year which ends June 30th. Dr. Ball asked if the Society could assist financially with cases and to accept the new cases from the Board of Health for the Easter Seal program.

This matter was referred to Dr. Green, co-chairman of the Easter Seal Society's Medical Advisory Board. Dr. Green, after conferring with a committee from the Medical Advisory Board, gave the following recommendations:

"Any cases needing emergency care between now and June 30, 1958 should be referred directly to the Crippled Children Society in order to secure assistance from the proper county chapter, if said chapter had funds available."

This information was presented to county chapters and much assistance has been given by Easter Seal chapters to the Board of Health and to local County Health Departments since that date.

II. *SERVICES PROVIDED BY COUNTY CHAPTERS*

Clinics at Rock Hill and Spartanburg

Treatment Centers: Aiken, Charleston, Greenville, Greenwood, Rock Hill and Spartanburg

Speech Correction Projects: Beaufort, Calhoun, Charleston, Chester, Richland, Greenville

Special education or homebound teaching aid is granted by many of the county chapters working in cooperation with their local school systems

Nursery school or pre-school centers for handicapped children

Orthopedic aids or appliances on medical prescription

Equipment loan pools

EDUCATION OF THE PUBLIC

Progress has been made by the Easter Seal Society

in informing the public of the needs of the handicapped through:

Newspaper articles and feature stories

Radio and television broadcasts

Films such as "Search" and "A Day in the Life of a Cerebral Palsy Child"

Exhibits and speeches at meetings of civic and service groups

Pamphlets and brochures

RESEARCH

The Crippled Children Society of South Carolina, Inc., participates in the *National Easter Seal Research Foundation* for research into causes, prevention, and treatment of crippling conditions. Two per cent of all Easter Seal income is earmarked for Research.

The Medical College of South Carolina has been awarded, during the past year, two grants totaling \$10,265.00 for a research project under direction of Isabel Lockard, Ph.D. of the Department of Anatomy.

CURRENT PROJECTS

I. *Sheltered Workshop Committee*

The Board of Trustees of the Crippled Children Society of South Carolina recommended the setting-up of a joint study committee with representation from both the Easter Seal Society and the State Agency of Vocational Rehabilitation. The committee is to formulate recommendations regarding a Sheltered Workshop program for South Carolina for presentation to the boards of the two agencies for further action.

II. *Speech Correction Bill Becomes Law*

The Board of Trustees requested the State Board of Education to give a broader interpretation of the Special Education Bill. Such an interpretation would include state aid to local school systems from the State Department of Education for speech correctionists at the local level.

Dr. Jesse T. Anderson, State Superintendent of Education, felt that the state legislature should pass this instead of having just an interpretation from the State Board of Education. The legislature passed the bill which was signed by the Governor on April 9, 1958.

This means that in the future, speech correction will become a regular part of South Carolina's school program.

III. *Easter Seal Family Camp*

The Crippled Children Society of South Carolina plans to sponsor a three-day demonstration project to be held in August. This will be an Easter Seal Family Camp and from ten to twelve families of crippled children will be invited to participate in this project which will serve a three-fold purpose: period of recreation for the children, guidance from professional staff for parents, along with recreation.

SUMMARY OF SERVICES RENDERED

The following report of the Crippled Children Society of South Carolina, Inc. for the past fiscal year

includes the service programs of both the State Society and all county chapters:

	Total	Children	Adults
Arthritis	34	5	29
Cerebral palsy	484	448	36
Poliomyelitis	102	90	12
Muscular dystrophy	36	34	2
Multiple sclerosis	6	4	2
Orthopedic	522	340	182
Speech disorders	306	303	3
Speech testing	3,726	3,726	--
Other	548	458	90
Occupational therapy (group therapy)	819	542	277
Total handicapped persons served by state and county affiliates	6,583	5,950	633
Professional training (teachers, therapists, etc.)	231	--	231
TOTAL NUMBER SERVED IN SOUTH CAROLINA	6,814	5,950	864
ANNUAL FINANCIAL REPORT			

This report, prepared by A. C. Clarkson & Company, certified public accountants, summarizes the financial activities for the past year:

Care and Treatment Services	\$145,056.68
Research	3,267.52
Education	18,834.34
Administrative Costs	15,679.95
Fund Raising	14,837.26

Total spent during the past year \$197,675.75
(from Easter Seal Campaign and
special donations)

CONCLUSION

Without the assistance and the backing of an active Medical Advisory Committee, and an outstanding group of loyal volunteers, this report could not have been written.

Our appreciation for your outstanding leadership cannot be expressed in words. In your profession you have done much to bring comfort to the ill. By serving on the Medical Advisory Committee, you have continued to help the Society bring comfort and care to handicapped persons throughout South Carolina.

Mrs. T. Jackson Lowe
Executive Director

May 8, 1958

BOOK REVIEW

THE NURSING MOTHER. By Frank Howard Richardson, M. D. Cloth. \$2.95, Pp. 199 and an index; also a pediatric and an obstetric introduction. Tupper & Love, Atlanta, and David McKay Co., New York City, 1953.

Long, long ago—in the second century A. D.—Soranus of Ephesus (Asia Minor) had stated in his famous and authoritative book on *Diseases of Women*, that breasts were not given to women solely for beauty. But within the past 25 or 30 years women and doctors seem to have forgotten this truism. For with the great improvement in cows milk, its preservation and the numerous powdered and liquid canned milks on the market, bottle feeding has become so simple and safe that it is almost routinely used by a great many people.

Also since World War II, a very large number of mothers are gainfully employed, and thus absent from the home for many hours in the day. Further the automobile and the marked increase in social gather-

ings of women have also caused them to be out of the house much of the time.

A great many young doctors to save time and argument usually put the baby on the bottle. Further in some medical schools, little attention is given to the subject of breast feeding, or at least its advantages are not sufficiently stressed.

So it is quite refreshing and timely, that Dr. Richardson should write a book on breast feeding. In this clear, practical and informative volume, he discusses the technic of nursing, pointing out its many advantages. Further the author supports his statements with statistics and opinions from many sources here and abroad by eminent authorities.

To make the subject more easily understood and also more informal, of the 24 chapters, a number are in question and answer form.

This manual should be of great value not only to the expectant and nursing mother, but to a host of young doctors who have had little opportunity to learn of the advantages of breast feeding, and to many of them who are pessimistic about that subject.

R. M. Pollitzer, M. D.

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